



October 2024

Molina Healthcare

Medicaid

**Preferred Drug List
(Formulary)/
Lista de Medicamentos
Preferidos
(Formulario)**



Discrimination is against the law

Molina Healthcare (Molina) follows the law. We treat all people equally.

We do not discriminate against anyone based on:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion

We provide free help and services to people with disabilities. We want you to be able to communicate with us easily.

We offer:

- Qualified sign language interpreters.
- Written information in many formats. These may include:
 - Large print
 - Audio
 - Accessible electronic formats
 - Other formats

We also provide free language services to people whose first language is not English. We offer:

- Qualified interpreters
- Information that is written in other languages

Contact us at (800) 424-4518 (TTY/TDD: 711) if you need any of these services.

The AlertLine offers confidential and anonymous reporting without fear of retaliation. If you believe there have been instances of non-compliance, potential fraud, waste or abuse or have experienced discrimination, you may file a report by calling the Molina AlertLine at (866) 606-3889 or online at <https://molinahealthcare.alertline.com>

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You may do this online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Or you may do this by mail or phone:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

(800) 368-1019

TDD: (800) 537-7697

Complaint forms are available online. You may find them at <http://www.hhs.gov/ocr/office/file/index.html>.

Help in other languages

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 424-4518 (TTY/TDD: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어지원서비스를 무료로 이용하실 수 있습니다.

(800) 424-4518 (TTY/TDD: 711) 번으로 전화해 주십시오.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 424-4518 (TTY/TDD: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (TTY/TDD: 711) (800) 424-4518.

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان، اتصل برقم (1-800-424-4518) رقم هاتف الصم والبكم: (711) -قم هاتف الصم والبكم: .

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa (800) 424-4518 (TTY/TDD: 711).

Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات راهنمای زبان به صورت رایگان برای شما در دسترس است. با شماره 4518-424 (800) TTY/TDD (تعماریه ونه ته بینوایان 711)); تعماریه ونه ته بینوایان تماس بگیرید

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገኙዎት ተዘጋጅተዋል። ወደ ማከተለው ቁጥር ይደውሉ

Urdu

دعیمان دین: اگر آپ اردو بولتے ہیں تو مشق زبان کی مدد والی خل ما شت دستیاب ہیں۔ (711 بلس --800-424 TTY/TDD) 4518: میڈ لین۔ پیکریں کال۔

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 424-4518 (ATS: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. ЗВОНИТЕ (800) 424-4518 (Телетайп: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

(800) 424-4518 (TTY/TDD: 711) पर कर्ाल करे ।

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer (800) 424-4518 (TTY/TDD: 711).

Bengali

লক্ষ্য: করনঃ যিদ আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পা রেখবা। উপল আছা ফোন করন।

(800) 424-4518 (TTY/TDD: 711).

Bassa

Dè dè nià kè dyédé gbo: ɔ juú ké m̀ Bàsò ɔ-wùdù-po-nyò juú ní, níí, à wudu kà kò do po-poó bé in m̀ gbo kpáa. Đá (800) 424-4518 (TTY/TDD: 711).

CONTENTS/CONTENIDO

(10/01/2024)

FORMULARY GUIDE (ENGLISH)

INTRODUCTION

We are pleased to provide the *2024 Molina Healthcare (Molina) Preferred Drug List (Formulary)* as a useful reference and informational tool. This guide can help medical providers select clinically appropriate and cost-effective products for their patients.

The drugs in this guide have been reviewed by a Pharmacy and Therapeutics (P&T) Committee and are approved before being included. This guide reflects current medical practice as of the date of review.

The information in this guide is provided solely for the benefit of medical providers. We do not guarantee accuracy of such information. This guide is not intended to be comprehensive in nature. All the information in the guide is provided as a reference for drug therapy selection.

This guide is subject to state-specific regulations and rules, including, but not limited to, those about generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

Molina is not responsible for the actions or omissions of any medical provider based on information in this guide. The medical provider should check the drug manufacturer's product literature or standard references for more detailed information.

PREFACE

This guide is organized by sections. Each section is divided by therapeutic drug class by type.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

We use the services of a Pharmacy and Therapeutics Committee ("P&T Committee") to approve safe and clinically effective drug therapies. The P&T Committee is an advisory body of clinical professionals. The P&T Committee's voting members include physicians and pharmacists who all have a broad background of clinical and academic expertise on prescription drugs. Voting members of the P&T Committee must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

DRUG LIST PRODUCT DESCRIPTIONS

To help you understand which specific strengths and dosage forms are covered, some general guidelines are noted below.

- The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIPITOR). Generic drugs are listed in lowercase italics (e.g., atorvastatin).

- The second column (labeled Drug Tier) will list what tier the drug is placed on in the Drug Formulary.
- The third column (Requirements/Limits) contains any special requirements for coverage of your drug.
- If the OTC and prescription versions of the product are covered, then both are listed.
- Extended-release and delayed-release products require their own entry.
- Dosage forms will be consistent with the category and use where listed.

GENERIC SUBSTITUTION

Generic substitution is when your pharmacy may dispense a generic version instead of a prescribed brand-name product. In this guide, lowercase italicized type means a generic version is available. In most instances, if there's a generic product available, the brand-name version will become non-formulary. The generic product will be covered instead of the brand-name version. However, this guide is subject to state specific regulations and rules for generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Usually priced lower than their brand-name equivalents
- Approved by the U.S. Food and Drug Administration for safety and effectiveness. They are manufactured under the same strict standards that apply to brand-name drugs
- Tested in humans to make sure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter how safe and effective they are
- Manufactured in the same strength and dosage form as the brand-name drugs

When a generic drug is substituted for a brand-name drug, the generic should be just as safe and effective as the brand-name drug (therapeutic equivalence).

PLAN DESIGN

- This guide represents Molina and Virginia Medicaid's Common Core Formulary. Generic medications are typically available at the lowest cost. Brand-name medications usually cost more than generic versions. Medications not on the list will usually cost the most.

This guide lists drugs in the following manner:

Preferred Drugs

Non-Preferred Drugs

The medications listed in this guide are covered by Molina as represented. Molina covers certain medications on the list if utilization management criteria are met (i.e., Step Therapy, Prior Authorization, Quantity Limits, etc.). Molina will review requests for such medications outside of their listed criteria for medical necessity. If a medication is not listed, you may request a formulary exception for coverage. We will review medical necessity or formulary exception requests based on

drug-specific prior authorization criteria or standard non-formulary prescription request criteria. Log into molinahealthcare.com to check coverage.

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when formulary options have proven not to work. When this happens, the physician may fax a completed drug prior authorization form to Molina at (844) 278-5731. You can find these forms at molinahealthcare.com. We will not consider trials of pharmaceutical samples as rationale for approving a prior authorization request.

PRIOR AUTHORIZATION HELPFUL HINTS

For the quickest response possible from Molina's pharmacy department, please provide relevant information with the Prior Authorization request.

The following are examples:

Class of Medication/Diagnosis	Requested Clinical Information
Cholesterol Lowering	Lipid Panel, Cardiovascular risk factors
Diabetes	A1c Report
Non-Formulary/Non-Preferred Medication	Medication Log and/or Progress Notes documenting previous use of Formulary medications

EXCLUDED SERVICES

Please note that certain medications are excluded. These include, but are not limited to:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- Drugs which have been recalled
- Experimental drugs or non-FDA-approved drugs
- Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

NOTICE

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This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

LEGEND

AGE	Age Limit
CL	Closed Class Medication
MED	Max 90 mg Morphine Equivalent Dose per day
OTC	Over-the-counter, covered benefit with a prescription
PA	Prior Authorization
PA, QL	Quantity Limit is applied after Prior Authorization approval
QL	Quantity Limit
SP	Specialty Drug
ST	Step Therapy
<i>lowercase</i>	Indicates generic availability
UPPERCASE	Indicates brand availability

Product Name	Change	Notes	Effective Date
ADDERALL XR	Update to non-preferred	PA required	10/1/2024
ADEFOVIR DIPIVOXIL	Add to formulary as non-preferred	PA required	10/1/2024
AGAMREE	Add to formulary as non-preferred	PA required	10/1/2024
ALVESCO	Update to preferred Remove PA		10/1/2024
AMONDYS-45	Add to formulary as non-preferred	PA required	10/1/2024
ASMANEX HFA	Update to preferred Remove PA		10/1/2024
BARACLUDE	Add to formulary as non-preferred	PA required	10/1/2024
CARBAMAZEPINE ER TABLET	Update to preferred Remove PA		10/1/2024
DARUNAVIR TABLET	Update to preferred Remove PA		10/1/2024
DEFLAZACORT	Add to formulary as non-preferred Add age limit	PA required Age limit = Maximum age 2	10/1/2024
DEXTROAMPHETAMINE ER CAPSULE	Update to preferred Remove PA Add quantity limit	Quantity limit = 1 capsule per day	10/1/2024
DEXTROAMPHETAMINE-AMPHETAMINE ER CAPSULE	Update to preferred Remove PA		10/1/2024
EMFLAZA	Update to preferred Remove PA		10/1/2024
ENTECAVIR 0.5 MG TABLET	Remove PA Remove quantity limit		10/1/2024
ENTECAVIR 1 MG TABLET	Remove quantity limit		10/1/2024

EXONDYS-51	Add to formulary as non-preferred	PA required	10/1/2024
FLUTICASONE DISKUS	Update to non-preferred	PA required	10/1/2024
FLUTICASONE HFA	Update to non-preferred	PA required	10/1/2024
FULPHILA	Add to formulary as preferred		10/1/2024
FYLNETRA	Add to formulary as non-preferred	PA required	10/1/2024
GLUCAGON EMERGENCY KIT	Update to non-preferred	PA required	10/1/2024
GRANIX	Add to formulary as non-preferred	PA required	10/1/2024
GVOKE	Update to non-preferred	PA required	10/1/2024
GVOKE HYOPEN	Update to non-preferred	PA required	10/1/2024
HEPSERA	Add to formulary as non-preferred	PA required	10/1/2024
INVOKAMET	Update to non-preferred	PA required	10/1/2024
INVOKANA	Update to non-preferred	PA required	10/1/2024
LAMIVUDINE HBV	Add to formulary as preferred		10/1/2024
LEUKINE	Add to formulary as non-preferred	PA required	10/1/2024
NEULASTA	Add to formulary as non-preferred	PA required	10/1/2024

NEULASTA ONPRO	Add to formulary as non-preferred	PA required	10/1/2024
NEUPOGEN	Add to formulary as preferred		10/1/2024
NIVESTYM	Add to formulary as non-preferred	PA required	10/1/2024
NUTROPIN AQ NUSPIN	Update to non-preferred	PA required	10/1/2024
NYVEPRIA	Add to formulary as non-preferred	PA required	10/1/2024
PREZISTA	Update to non-preferred	PA required	10/1/2024
QVAR REDIHALER	Update to preferred Remove PA		10/1/2024
RELEUKO	Add to formulary as non-preferred	PA required	10/1/2024
ROLVEDON	Add to formulary as non-preferred	PA required	10/1/2024
SIMLANDI(CF) AUTO-INJECTOR	Add to formulary as non-preferred Add age limit	PA required Age limit = Minimum age 2	10/1/2024
STIMUFEND	Add to formulary as non-preferred	PA required	10/1/2024
SYNJARDY XR	Update to preferred Remove PA		10/1/2024
TYENNE	Add to formulary as non-preferred Add age limit	PA required Age limit = Minimum age 2	10/1/2024
UDENYCA	Add to formulary as non-preferred	PA required	10/1/2024
VALTOCO	Update to non-preferred	PA required	10/1/2024

VEMLIDY	Add to formulary as non-preferred	PA required	10/1/2024
VILTEPSO	Add to formulary as non-preferred	PA required	10/1/2024
VYONDYS-53	Add to formulary as non-preferred	PA required	10/1/2024
VYVANSE CHEWABLE TABLET	Update to non-preferred	PA required	10/1/2024
ZARXIO	Update to non-preferred	PA required	10/1/2024
ZEGALOGUE	Update to preferred Remove PA		10/1/2024
ZIEXTENZO	Update to non-preferred	PA required	10/1/2024

GUÍA DE FORMULARIO (ESPAÑOL)

INTRODUCCIÓN

Nos complace proporcionar *Lista de Medicamentos Preferidos de [Molina Healthcare (Molina)] [2024] (Formulario)* como una herramienta de referencia e información útil. Esta guía puede ayudar a los proveedores médicos a seleccionar productos clínicamente apropiados y rentables para sus pacientes.

Los medicamentos que se indican en esta guía fueron revisados por un Comité de Farmacia y Terapéutica (P&T, *Pharmacy and Therapeutics*) y están aprobados antes de su inclusión. Esta guía refleja la práctica médica actual a la fecha de revisión.

La información en esta guía se proporciona únicamente para el beneficio de los proveedores médicos. No garantizamos la exactitud de dicha información. Esta guía no fue hecha con un propósito integral. Toda la información de esta guía se proporciona como referencia para la selección de la terapia con medicamentos.

Esta guía está sujeta a normas y reglamentos específicos del estado, incluidos, entre otros, aquellos relacionados con la sustitución genérica, los programas de sustancias de administración controlada, la preferencia de marcas y los genéricos obligatorios cuando corresponda.

[Molina] no asume la responsabilidad por las acciones u omisiones de cualquier proveedor médico en función de la información contenida en esta guía. El proveedor médico debe revisar la documentación del producto provista por el fabricante del medicamento o las referencias estándar para obtener información más detallada.

PREFACIO

Esta guía está organizada en secciones. Cada sección se divide según la clase terapéutica del fármaco, por tipo.

COMITÉ DE FARMACIA Y TERAPÉUTICA (P&T)

Utilizamos los servicios de un Comité de Farmacia y Terapéutica (P&T) para aprobar tratamientos con medicamentos seguros y clínicamente eficaces. El Comité de P&T es un organismo asesor de profesionales clínicos. Entre los miembros votantes del Comité de P&T, se encuentran médicos y farmacéuticos, los cuales tienen una amplia experiencia clínica y académica en medicamentos recetados. Los miembros votantes del Comité de P&T deben divulgar cualquier relación financiera o conflicto de intereses con cualquier fabricante farmacéutico.

DESCRIPCIONES DE LOS PRODUCTOS DE LA LISTA DE MEDICAMENTOS

Para ayudar a entender cuáles son las fortalezas específicas y las formas de dosificación cubiertas, algunas pautas generales se describen a continuación.

- En la primera columna del cuadro se indica el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (p. ej., LIPITOR). Los medicamentos genéricos se indican en letra minúscula en cursiva (p. ej., atorvastatin).
- En la segunda columna (categoría de medicamento etiquetado) se indica en qué categoría se ubica el medicamento en el formulario.
- La tercera columna (Requisitos/Límites) contiene cualquier requisito especial para la cobertura de su medicamento.
- Si las versiones de productos de venta libre (OTC, *Over The Counter*) y las versiones de productos con receta médica están cubiertas, se indican ambas.
- Los productos de liberación prolongada y de liberación retardada requieren su propia entrada.
- Las formas de dosificación serán coherentes con la categoría y el uso en que se clasificaron.

SUSTITUCIÓN GENÉRICA

La sustitución genérica es cuando su farmacia puede administrar una versión genérica en lugar de un producto de marca recetado. En esta guía, la letra minúscula en cursiva significa que hay una versión genérica disponible. En la mayoría de los casos, si hay un producto genérico disponible, la versión de marca registrada no tendrá formulario. El producto genérico estará cubierto en lugar de la versión de marca registrada. Sin embargo, esta guía está sujeta a regulaciones y normas específicas del estado sobre la sustitución genérica y se aplican normas genéricas obligatorias si corresponde.

Los medicamentos genéricos con receta médica cuentan con las siguientes características:

- Normalmente, tienen un precio menor que sus equivalentes de marca.
- Están aprobados por la Administración de Alimentos y Medicamentos de los EE. UU. en términos de seguridad y eficacia. Se fabrican bajo las mismas normas estrictas que se aplican a medicamentos de marca.
- Se probaron en humanos para garantizar que el genérico sea absorbido en el torrente sanguíneo en una tasa y extensión similares en comparación con el medicamento de marca (bioequivalencia). Los genéricos pueden ser diferentes de los de la marca en cuanto a tamaño, color e ingredientes inactivos, pero esto no altera lo efectivos ni seguros que son.
- Se fabrican con la misma concentración y dosificación que los medicamentos de marca.

Cuando un medicamento genérico es sustituido por un medicamento de marca, el medicamento genérico debe ser igual de efectivo y seguro que el medicamento de marca (equivalencia terapéutica).

DISEÑO DE PLANES

Esta guía representa el Formulario Básico Común de [Molina] y Virginia Medicaid. Los medicamentos que se presentan en el documento pueden tener un costo variable para el miembro del plan. Los medicamentos genéricos suelen estar disponibles al menor precio. Los medicamentos de marca, por lo general, serán más caros que las versiones genéricas. Los medicamentos que no están presentes en la lista suelen tener el mayor precio.

En esta guía se indican los medicamentos de la siguiente manera:

Categoría 1: Medicamentos Genéricos Preferidos

Categoría 2: Medicamentos de Marca Preferidos

Categoría 3: Medicamentos de Marca no Preferidos: Los medicamentos que no aparecen en el documento se consideran como “No Preferidos”

Los medicamentos que aparecen en esta guía están cubiertos por [Molina] según lo que se representa. [Molina] cubra algunos medicamentos de la lista si se cumplen los criterios de administración de utilización (es decir, terapia progresiva, autorización previa, límites de cantidad, etc.). [Molina] revisará las solicitudes de dichos medicamentos que estén fuera de los criterios enumerados se revisarán según la necesidad médica. Si un medicamento no aparece, puede solicitar una excepción de formulario para la cobertura. Revisaremos las solicitudes de necesidad médica o de excepción de formulario en función de los criterios de autorización previos específicos para el medicamento o los criterios estándar de solicitud de receta médica no convencional. Inicie sesión en [molinahealthcare.com] para revisar la cobertura.

PROCEDIMIENTO DE SOLICITUD DE AUTORIZACIÓN PREVIA

Las recetas de medicamentos que requieren aprobación previa o para medicamentos que no están incluidos en el Formulario de Medicamentos de [Molina] pueden ser aprobadas cuando son médicamente necesarias y cuando se haya demostrado que las alternativas del formulario no funcionan. Cuando esto ocurra, su proveedor puede enviar por fax un formulario completado de autorización previa de medicamentos a [Molina] al [(844) 278-5731]. Puede encontrar estos formularios en [molinahealthcare.com]. No consideraremos los ensayos de muestras farmacéuticas como justificativos para la aprobación de una solicitud de autorización previa.

CONSEJOS ÚTILES DE AUTORIZACIÓN PREVIA

Para la respuesta más rápida posible del Departamento de Farmacia de [Molina], proporcione la información pertinente con la solicitud de autorización previa.

Observe los siguientes ejemplos:

Clase de medicamento o diagnóstico	Información clínica solicitada
Reducción de colesterol	Perfil lipídico, factores de riesgo cardiovasculares
Diabetes	Resultados de prueba de A1c
Medicamento no preferido/fuera del formulario	Los Registros de Medicamentos o Notas de Progreso en los cuales se documente que el medicamento del formulario se utilizó con anterioridad

SERVICIOS EXCLUIDOS

Tenga en cuenta que algunos medicamentos están excluidos. Estos incluyen, entre otros:

- Medicamentos contra la anorexia, pérdida de peso o aumento de peso.
- Medicamentos para promover la fertilidad.
- Medicamentos para fines cosméticos o el crecimiento del cabello.
- Medicamentos para el tratamiento de disfunción sexual o eréctil; a menos que dichos medicamentos se utilicen para tratar una afección distinta de la disfunción eréctil; para la que los medicamentos estén aprobados por la FDA.
- Todos los medicamentos DESI (*Drug Efficacy Study Implementation*, Implementación del Estudio de la Eficacia de los Medicamentos) que, según la definición de la FDA, no tengan el nivel requerido de eficacia. Recetas de compuestos, lo que incluye medicamentos DESI no cubiertos.
- Medicamentos que se hayan retirado del Mercado.
- Medicamentos experimentales o no aprobados por la FDA.
- Cualquier medicamento de venta bajo receta archivada que se comercialice por un fabricante no perteneciente al Programa de Devolución de Medicamentos de Medicaid.

AVISO

La información contenida en esta guía es patentada. La información no se puede copiar en su totalidad o en parte sin el permiso por escrito. ©2024. Todos los derechos reservados.

Este documento contiene referencias a medicamentos con receta que son marcas comerciales o marcas comerciales registradas de fabricantes farmacéuticos.

LEYENDA

AGE	Límite de edad
CL	Medicamentos de Clase Cerrada
MED	Dosis equivalente de morfina de 90 mg como máximo por día
OTC	Medicamento de venta libre, beneficio cubierto con una receta médica
PA	Autorización previa
PA, QL	Límite de cantidad que se aplica después de la aprobación de la Autorización Previa
QL	Límite de Cantidad
SP	Medicamento de especialidad
ST	Terapia progresiva
<i>minúscula</i>	Indica disponibilidad genérica
MAYÚSCULA	Indica disponibilidad de la marca

Product Name	Change	Notes	Effective Date
ADDERALL XR	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
ADEFOVIR DIPIVOXIL	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
AGAMREE	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
ALVESCO	Actualizar a preferido Eliminar autorización previa		10/1/2024
AMONDYS-45	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
ASMANEX HFA	Actualizar a preferido Eliminar autorización previa		10/1/2024
BARACLUDE	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
CARBAMAZEPINE ER TABLET	Actualizar a preferido Eliminar autorización previa		10/1/2024
DARUNAVIR TABLET	Actualizar a preferido Eliminar autorización previa		10/1/2024
DEFLAZACORT	Agregar al formulario como no preferido Agregar límite de edad	Se requiere autorización previa Límite de edad = edad máxima 2	10/1/2024
DEXTROAMPHETAMINE ER CAPSULE	Actualizar a preferido Eliminar autorización previa Agregar límite de cantidad	Límite de cantidad = 1 cápsula por día	10/1/2024
DEXTROAMPHETAMINE-AMPHETAMINE ER CAPSULE	Actualizar a preferido Eliminar autorización previa		10/1/2024
EMFLAZA	Actualizar a preferido Eliminar autorización previa		10/1/2024

ENTECAVIR 0.5 MG TABLET	Eliminar autorización previa Eliminar límite de cantidad		10/1/2024
ENTECAVIR 1 MG TABLET	Eliminar límite de cantidad		10/1/2024
EXONDYS-51	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
FLUTICASONE DISKUS	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
FLUTICASONE HFA	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
FULPHILA	Agregar al formulario como preferido		10/1/2024
FYLNETRA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
GLUCAGON EMERGENCY KIT	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
GRANIX	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
GVOKE	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
GVOKE HYPOPEN	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
HEPSERA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
INVOKAMET	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
INVOKANA	Actualizar a no preferido	Se requiere autorización previa	10/1/2024

LAMIVUDINE HBV	Agregar al formulario como preferido		10/1/2024
LEUKINE	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NEULASTA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NEULASTA ONPRO	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NEUPOGEN	Agregar al formulario como preferido		10/1/2024
NIVESTYM	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NUTROPIN AQ NUSPIN	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
NYVEPRIA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
PREZISTA	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
QVAR REDHALER	Actualizar a preferido Eliminar autorización previa		10/1/2024
RELEUKO	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
ROLVEDON	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
SIMLANDI(CF) AUTO-INJECTOR	Agregar al formulario como no preferido Agregar límite de edad	Se requiere autorización previa Age limit = Minimum age 2	10/1/2024
STIMUFEND	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024

SYNJARDY XR	Actualizar a preferido Eliminar autorización previa		10/1/2024
TYENNE	Agregar al formulario como no preferido Agregar límite de edad	Se requiere autorización previa Age limit = Minimum age 2	10/1/2024
UDENYCA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VALTOCO	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
VEMLIDY	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VILTEPSO	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VYONDYS-53	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VYVANSE CHEWABLE TABLET	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
ZARXIO	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
ZEGALOGUE	Actualizar a preferido Eliminar autorización previa		10/1/2024
ZIEXTENZO	Actualizar a no preferido	Se requiere autorización previa	10/1/2024

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Drug Name	Formulary Status	Requirements/Limits
ACNE AGENTS: TOPICAL [OPEN CLASS]		
<i>acne medication 10 external gel 10 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>acne medication 10 external lotion 10 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>acne medication 2.5 external gel 2.5 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>acne medication 5 external gel 5 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>acne medication 5 external lotion 5 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>adapalene external gel 0.1 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>benzoyl peroxide external gel 10 %, 2.5 %, 5 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>benzoyl peroxide external liquid 10 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>benzoyl peroxide wash external liquid 10 %, 5 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>clindamycin phosphate external solution 1 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>clindamycin phosphate external swab 1 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>clindamycin phosphate gel 1 % external</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>erythromycin external solution 2 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>lintera wash external foam 10 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>tazarotene external foam 0.1 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Min 12 Years and Max 18 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>tretinoin external gel 0.01 %, 0.025 %</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>clindamycin phosphate (Clindacin Etz External Swab 1 %)</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>clindamycin phosphate (Clindacin-P External Swab 1 %)</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
RETIN-A EXTERNAL CREAM 0.025 %, 0.05 %, 0.1 % (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
RETIN-A EXTERNAL GEL 0.01 %, 0.025 % (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
<i>adapalene external cream 0.1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>adapalene external gel 0.3 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %, 0.3-2.5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>bp 10-1 external emulsion 10-1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>bp cleansing wash external emulsion 10-4 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>bpo foaming cloths external 6 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate external foam 1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate external lotion 1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate gel 1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin-tretinoin external gel 1.2-0.025 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>dapsone external gel 5 %, 7.5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>ery external pad 2 %</i>	Non Preferred	PA; AGE (Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>erythromycin external gel 2 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sodium sulfacetamide external shampoo 10 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sodium sulfacetamide wash external liquid 10 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sss 10-5 external cream 10-5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sss 10-5 external foam 10-5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium (cleans) external gel 10 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium external liquid 10 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9-4.5 %, 9.8-4.8 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur external pad 10-4 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sod-sulfur wash external liquid 9-4.5 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tazarotene external cream 0.05 %, 0.1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tazarotene external gel 0.05 %, 0.1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin external gel 0.05 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %</i>	Non Preferred	PA; AGE (Max 18 Years)
ACANYA EXTERNAL GEL 1.2-2.5 % (<i>clindamycin phos-benzoyl perox</i>)	Non Preferred	PA; AGE (Max 18 Years)
ALTRENO EXTERNAL LOTION 0.05 % (<i>tretinoin</i>)	Non Preferred	PA; AGE (Max 18 Years)
ARAZLO EXTERNAL LOTION 0.045 % (<i>tazarotene</i>)	Non Preferred	PA; AGE (Max 18 Years)
ATRALIN EXTERNAL GEL 0.05 % (<i>tretinoin</i>)	Non Preferred	PA; AGE (Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>sulfacetamide sodium-sulfur</i> (Avar Cleanser External Liquid 10-5 %)	Non Preferred	PA; AGE (Max 18 Years)
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur</i> (Avar-E Emollient External Cream 10-5 %)	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur</i> (Avar-E Green External Cream 10-5 %)	Non Preferred	PA; AGE (Max 18 Years)
AVAR-E LS EXTERNAL CREAM 10-2 % (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
BENZAMYCIN EXTERNAL GEL 5-3 % (<i>benzoyl peroxide-erythromycin</i>)	Non Preferred	PA; AGE (Max 18 Years)
BENZEFOAM EXTERNAL FOAM 5.3 % (<i>benzoyl peroxide</i>)	Non Preferred	PA; AGE (Max 18 Years)
CABTREO EXTERNAL GEL 0.15-3.1-1.2 % (<i>adapalene-benzoyl per-clindamy</i>)	Non Preferred	PA; AGE (Min 12 Years)
CLEOCIN-T EXTERNAL LOTION 1 % (<i>clindamycin phosphate</i>)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN ETZ EXTERNAL KIT 1 % (<i>clindamycin phos & cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate</i> (Clindacin External Foam 1 %)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN PAC EXTERNAL KIT 1 % (<i>clindamycin phos & cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
CLINDAGEL EXTERNAL GEL 1 % (<i>clindamycin phosphate</i>)	Non Preferred	PA; AGE (Max 18 Years)
DERMACINRX ATRIX ANTIBAC WASH EXTERNAL LIQUID 2 % (<i>salicylic acid</i>)	Non Preferred	PA; AGE (Max 18 Years)
ERYGEL EXTERNAL GEL 2 % (<i>erythromycin</i>)	Non Preferred	PA; AGE (Max 18 Years)
EVOCLIN EXTERNAL FOAM 1 % (<i>clindamycin phosphate</i>)	Non Preferred	PA; AGE (Max 18 Years)
FABIOR EXTERNAL FOAM 0.1 % (<i>tazarotene</i>)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
<i>clindamycin-benzoyl per (refr)</i> (Neuac External Gel 1.2-5 %)	Non Preferred	PA; AGE (Max 18 Years)
NEUAC EXTERNAL KIT 1.2-5 % (<i>clindamycin-benzoyl per-moist</i>)	Non Preferred	PA; AGE (Max 18 Years)
ONEXTON EXTERNAL GEL 1.2-3.75 % (<i>clindamycin phos-benzoyl perox</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS EXTERNAL CREAM 10 % (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS EXTERNAL LOTION 9.8 % (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS EXTERNAL SHAMPOO 10 % (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
OVACE PLUS WASH EXTERNAL GEL 10 % (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS WASH EXTERNAL LIQUID 10 % (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE WASH EXTERNAL LIQUID 10 % (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO EXTERNAL GEL 0.04 %, 0.1 % (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO PUMP EXTERNAL GEL 0.04 %, 0.06 %, 0.08 %, 0.1 % (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN EXTERNAL KIT 9-4.5 % (<i>sulfacetamide-sulfur-cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN WASH EXTERNAL LIQUID 9-4.5 % (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN XLT EXTERNAL KIT 9-4.5 % (<i>sulfacetamide-sulfur-sunscreen</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMAXIN CP EXTERNAL KIT 10-4 % (<i>sulfacetamide-sulfur-cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
WINLEVI EXTERNAL CREAM 1 % (<i>clascoterone</i>)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
ZIANA EXTERNAL GEL 1.2-0.025 % (<i>clindamycin-tretinoin</i>)	Non Preferred	PA; AGE (Max 18 Years)
ZMA CLEAR EXTERNAL SUSPENSION 9-4.5 % (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
ALZHEIMER'S AGENTS [OPEN CLASS]		
<i>donepezil hcl oral tablet 10 mg, 23 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>memantine hcl oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	Preferred	90-day fill allowed after two 1-month fills
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	Non Preferred	PA
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	Non Preferred	PA
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	Non Preferred	PA
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	Non Preferred	PA
<i>memantine hcl oral solution 2 mg/ml</i>	Non Preferred	PA; 90-day fill allowed after two 1-month fills
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ADLARTY TRANSDERMAL PATCH WEEKLY 10 MG/DAY, 5 MG/DAY (<i>donepezil hcl</i>)	Non Preferred	PA
ARICEPT ORAL TABLET 10 MG, 23 MG, 5 MG (<i>donepezil hcl</i>)	Non Preferred	PA
EXELON TRANSDERMAL PATCH 24 HOUR 13.3 MG/24HR, 4.6 MG/24HR, 9.5 MG/24HR (<i>rivastigmine</i>)	Non Preferred	PA
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 & 28 -10 MG (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA; QL (28 EA per 180 days)
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA
ANDROGENIC AGENTS [OPEN CLASS]		
<i>testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)</i>	Preferred	AGE (Min 18 Years)
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR (<i>testosterone</i>)	Preferred	AGE (Min 18 Years)
ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%) (<i>testosterone</i>)	Preferred	AGE (Min 18 Years)
<i>testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone transdermal solution 30 mg/act</i>	Non Preferred	PA; AGE (Min 18 Years)
FORTESTA TRANSDERMAL GEL 10 MG/ACT (2%) (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
NATESTO NASAL GEL 5.5 MG/ACT (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO PUMP TRANSDERMAL GEL 12.5 MG/ACT (1%) (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%) (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTI-ALLERGENS: ORAL [OPEN CLASS]		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (<i>timothy grass pollen allergen</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 5 Years)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (<i>dust mite mixed allergen ext</i>)	Non Preferred	PA; AGE (Min 12 Years and Max 65 Years)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (<i>grass mix pollens allergen ext</i>)	Non Preferred	PA; AGE (Min 5 Years)
PALFORZIA (12 MG DAILY DOSE) ORAL 2 X 1 MG & 10 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (120 MG DAILY DOSE) ORAL 20 MG & 100 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (160 MG DAILY DOSE) ORAL 3 X 20 MG & 100 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)

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Drug Name	Formulary Status	Requirements/Limits
PALFORZIA (20 MG DAILY DOSE) ORAL 20 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (200 MG DAILY DOSE) ORAL 2 X 100 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (240 MG DAILY DOSE) ORAL 2 X 20 MG & 2 X 100 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (3 MG DAILY DOSE) ORAL 3 X 1 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (300 MG MAINTENANCE) ORAL PACKET 300 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (300 MG TITRATION) ORAL PACKET 300 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (40 MG DAILY DOSE) ORAL 2 X 20 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (6 MG DAILY DOSE) ORAL 6 X 1 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (80 MG DAILY DOSE) ORAL 4 X 20 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA INITIAL ESCALATION ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (<i>peanut powder-dnfp</i>)	Non Preferred	SP; PA; AGE (Min 4 Years)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (<i>short ragweed pollen ext</i>)	Non Preferred	PA; AGE (Min 5 Years)
ANTIBIOTICS: INHALED [CLOSED CLASS]		
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Preferred	SP; QL (280 ML per 28 days); AGE (Min 6 Years)
BETHKIS INHALATION NEBULIZATION SOLUTION 300 MG/4ML (<i>tobramycin</i>)	Preferred	SP; QL (224 ML per 28 days); AGE (Min 6 Years)
KITABIS PAK INHALATION NEBULIZATION SOLUTION 300 MG/5ML (<i>tobramycin</i>)	Preferred	SP; QL (280 ML per 28 days); AGE (Min 6 Years)
TOBI PODHALER INHALATION CAPSULE 28 MG (<i>tobramycin</i>)	Preferred	SP; PA; QL (224 EA per 28 days); AGE (Min 6 Years)
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	Non Preferred	SP; PA; QL (224 ML per 28 days); AGE (Min 6 Years)
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Non Preferred	SP; PA; QL (280 ML per 28 days); AGE (Min 6 Years)
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (<i>amikacin sulfate liposome</i>)	Non Preferred	PA; QL (235.2 ML per 28 days); AGE (Min 18 Years)
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (<i>aztreonam lysine</i>)	Non Preferred	SP; PA; QL (84 ML per 28 days); AGE (Min 7 Years)
TOBI INHALATION NEBULIZATION SOLUTION 300 MG/5ML (<i>tobramycin</i>)	Non Preferred	SP; PA; QL (280 ML per 28 days); AGE (Min 6 Years)
ANTICOAGULANTS [CLOSED CLASS]		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	Preferred	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (<i>apixaban</i>)	Preferred	
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (<i>apixaban</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>warfarin sodium</i> (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	Preferred	90-day fill allowed after two 1-month fills
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG (<i>dabigatran etexilate mesylate</i>)	Preferred	90-day fill allowed after two 1-month fills
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (<i>rivaroxaban</i>)	Preferred	90-day fill allowed after two 1-month fills
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG (<i>rivaroxaban</i>)	Preferred	90-day fill allowed after two 1-month fills
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (<i>rivaroxaban</i>)	Preferred	
<i>dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg</i>	Non Preferred	PA
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	Non Preferred	PA
ARIXTRA SUBCUTANEOUS SOLUTION 10 MG/0.8ML, 2.5 MG/0.5ML, 5 MG/0.4ML, 7.5 MG/0.6ML (<i>fondaparinux sodium</i>)	Non Preferred	PA
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (<i>dalteparin sodium</i>)	Non Preferred	PA
LOVENOX INJECTION SOLUTION 300 MG/3ML (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX INJECTION SOLUTION PREFILLED SYRINGE 100 MG/ML, 120 MG/0.8ML, 150 MG/ML, 30 MG/0.3ML, 40 MG/0.4ML, 60 MG/0.6ML, 80 MG/0.8ML (<i>enoxaparin sodium</i>)	Non Preferred	PA
PRADAXA ORAL PACKET 110 MG, 150 MG, 20 MG, 30 MG, 40 MG, 50 MG (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA; AGE (Max 12 Years)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (<i>edoxaban tosylate</i>)	Non Preferred	PA
ANTICONVULSANTS [CLOSED CLASS]		
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Preferred	
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Preferred	
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Preferred	
<i>carbamazepine oral suspension 100 mg/5ml, 200 mg/10ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>carbamazepine oral tablet 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>carbamazepine oral tablet chewable 100 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>clobazam oral suspension 2.5 mg/ml</i>	Preferred	
<i>clobazam oral tablet 10 mg, 20 mg</i>	Preferred	
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Preferred	
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ethosuximide oral capsule 250 mg</i>	Preferred	AGE (Min 3 Years); 90-day fill allowed after two 1-month fills
<i>ethosuximide oral solution 250 mg/5ml</i>	Preferred	AGE (Min 3 Years); 90-day fill allowed after two 1-month fills
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lacosamide solution 10 mg/ml oral</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levetiracetam oral solution 100 mg/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>phenobarbital oral elixir 20 mg/5ml</i>	Preferred	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	Preferred	
<i>phenytoin oral suspension 100 mg/4ml, 125 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>phenytoin oral tablet chewable 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>primidone oral tablet 125 mg</i>	Preferred	
<i>primidone oral tablet 250 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>valproic acid oral capsule 250 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>valproic acid oral solution 250 mg/5ml, 500 mg/10ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine</i>)	Preferred	90-day fill allowed after two 1-month fills
DIASTAT ACUDIAL RECTAL GEL 10 MG (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DIASTAT PEDIATRIC RECTAL GEL 2.5 MG (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DILANTIN ORAL CAPSULE 30 MG (<i>phenytoin sodium extended</i>)	Preferred	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (<i>cannabidiol</i>)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 1 Years)
<i>carbamazepine (Eptol Oral Tablet 200 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (<i>lamotrigine</i>)	Preferred	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (<i>midazolam (anticonvulsant)</i>)	Preferred	PA (Eligible for auto-PA approval); QL (10 EA per 30 days); AGE (Min 12 Years)
<i>phenytoin (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levetiracetam (Roweepra Oral Tablet 500 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lamotrigine (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (<i>carbamazepine</i>)	Preferred	90-day fill allowed after two 1-month fills
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (<i>oxcarbazepine</i>)	Preferred	90-day fill allowed after two 1-month fills
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)

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Drug Name	Formulary Status	Requirements/Limits
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	Non Preferred	PA
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Non Preferred	Authorized generic only; PA
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Non Preferred	Authorized generic only; PA
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Non Preferred	Authorized generic only; PA
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Non Preferred	PA
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	Non Preferred	PA
<i>felbamate oral suspension 600 mg/5ml</i>	Non Preferred	PA
<i>felbamate oral tablet 400 mg, 600 mg</i>	Non Preferred	PA
<i>lacosamide oral solution 100 mg/10ml, 50 mg/5ml</i>	Non Preferred	PA
<i>lacosamide solution 10 mg/ml oral</i>	Non Preferred	PA
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	Non Preferred	PA
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	Non Preferred	PA
<i>lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg</i>	Non Preferred	PA
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg</i>	Non Preferred	PA
<i>methsuximide oral capsule 300 mg</i>	Non Preferred	PA
<i>oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg, 600 mg</i>	Non Preferred	PA
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	Non Preferred	PA
<i>rufinamide oral suspension 40 mg/ml</i>	Non Preferred	PA
<i>rufinamide oral tablet 200 mg, 400 mg</i>	Non Preferred	PA
<i>topiramate er oral capsule er 24 hour sprinkle 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>topiramate er oral capsule extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	Non Preferred	PA
<i>vigabatrin oral packet 500 mg</i>	Non Preferred	PA
<i>vigabatrin oral tablet 500 mg</i>	Non Preferred	PA
APTiom ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (<i>eslicarbazepine acetate</i>)	Non Preferred	PA
BANZEL ORAL SUSPENSION 40 MG/ML (<i>rufinamide</i>)	Non Preferred	PA
BANZEL ORAL TABLET 200 MG, 400 MG (<i>rufinamide</i>)	Non Preferred	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (<i>brivaracetam</i>)	Non Preferred	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (<i>brivaracetam</i>)	Non Preferred	PA
CELONTIN ORAL CAPSULE 300 MG (<i>methsuximide</i>)	Non Preferred	PA
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	Non Preferred	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	Non Preferred	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	Non Preferred	PA
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (<i>stiripentol</i>)	Non Preferred	SP; PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (<i>stiripentol</i>)	Non Preferred	SP; PA
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (<i>phenytoin</i>)	Non Preferred	PA
DILANTIN ORAL CAPSULE 100 MG (<i>phenytoin sodium extended</i>)	Non Preferred	PA
DILANTIN ORAL SUSPENSION 125 MG/5ML (<i>phenytoin</i>)	Non Preferred	PA
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (<i>phenytoin</i>)	Non Preferred	PA
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 1500 MG (<i>levetiracetam</i>)	Non Preferred	PA
EPRONTIA ORAL SOLUTION 25 MG/ML (<i>topiramate</i>)	Non Preferred	PA
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine (antipsychotic)</i>)	Non Preferred	PA
FELBATOL ORAL SUSPENSION 600 MG/5ML (<i>felbamate</i>)	Non Preferred	PA
FELBATOL ORAL TABLET 400 MG, 600 MG (<i>felbamate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
FINTEPLA ORAL SOLUTION 2.2 MG/ML (<i>fenfluramine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (<i>perampanel</i>)	Non Preferred	PA
KEPPRA ORAL SOLUTION 100 MG/ML (<i>levetiracetam</i>)	Non Preferred	PA
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (<i>levetiracetam</i>)	Non Preferred	PA
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (<i>levetiracetam</i>)	Non Preferred	PA
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (<i>clonazepam</i>)	Non Preferred	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (<i>lamotrigine</i>)	Non Preferred	PA
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG (<i>diazepam</i>)	Non Preferred	PA; QL (10 EA per 30 days); AGE (Min 2 Years and Max 5 Years)
MYSOLINE ORAL TABLET 250 MG, 50 MG (<i>primidone</i>)	Non Preferred	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (<i>clobazam</i>)	Non Preferred	PA
ONFI ORAL TABLET 10 MG, 20 MG (<i>clobazam</i>)	Non Preferred	PA
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG, 600 MG (<i>oxcarbazepine</i>)	Non Preferred	PA
<i>phenytoin sodium extended</i> (Phenytek Oral Capsule 200 Mg, 300 Mg)	Non Preferred	PA
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (<i>topiramate</i>)	Non Preferred	PA
SABRIL ORAL PACKET 500 MG (<i>vigabatrin</i>)	Non Preferred	PA
SABRIL ORAL TABLET 500 MG (<i>vigabatrin</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG (<i>levetiracetam</i>)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Blue Oral Kit 35 X 25 Mg)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Green Oral Kit 84 X 25 Mg & 14X100 Mg)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Orange Oral Kit 42 X 25 Mg & 7 X 100 Mg)	Non Preferred	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (<i>clobazam</i>)	Non Preferred	PA
TEGRETOL ORAL SUSPENSION 100 MG/5ML (<i>carbamazepine</i>)	Non Preferred	PA
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	Non Preferred	PA
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (<i>topiramate</i>)	Non Preferred	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (<i>topiramate</i>)	Non Preferred	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (<i>oxcarbazepine</i>)	Non Preferred	PA
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (<i>topiramate</i>)	Non Preferred	PA
<i>vigabatrin</i> (Vigadrone Oral Packet 500 Mg)	Non Preferred	PA
<i>vigabatrin</i> (Vigadrone Oral Tablet 500 Mg)	Non Preferred	PA
<i>vigabatrin</i> (Vigpoder Oral Packet 500 Mg)	Non Preferred	PA
VIMPAT ORAL SOLUTION 10 MG/ML (<i>lacosamide</i>)	Non Preferred	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>lacosamide</i>)	Non Preferred	PA
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG (<i>cenobamate</i>)	Non Preferred	PA
ZARONTIN ORAL CAPSULE 250 MG (<i>ethosuximide</i>)	Non Preferred	PA; AGE (Min 3 Years)
ZARONTIN ORAL SOLUTION 250 MG/5ML (<i>ethosuximide</i>)	Non Preferred	PA; AGE (Min 3 Years)

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Drug Name	Formulary Status	Requirements/Limits
ZONISADE ORAL SUSPENSION 100 MG/5ML (<i>zonisamide</i>)	Non Preferred	PA
ZTALMY ORAL SUSPENSION 50 MG/ML (<i>ganaxolone</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ANTIDEPRESSANTS: OTHER [OPEN CLASS]		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>desvenlafaxine er oral tablet extended release 24 hour 100 mg, 50 mg</i>	Preferred	
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>phenelzine sulfate oral tablet 15 mg</i>	Preferred	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg</i>	Non Preferred	PA
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	Non Preferred	PA
<i>tranylcypromine sulfate oral tablet 10 mg</i>	Non Preferred	PA
<i>venlafaxine besylate er oral tablet extended release 24 hour 112.5 mg</i>	Non Preferred	PA
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg, 75 mg</i>	Non Preferred	PA
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 174 MG, 348 MG, 522 MG (<i>bupropion hbr</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (<i>dextromethorphan-bupropion</i>)	Non Preferred	PA
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG, 37.5 MG (<i>venlafaxine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day)
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 75 MG (<i>venlafaxine hcl</i>)	Non Preferred	PA
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (<i>selegiline</i>)	Non Preferred	PA
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (<i>levomilnacipran hcl</i>)	Non Preferred	PA
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (<i>levomilnacipran hcl</i>)	Non Preferred	PA
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG (<i>bupropion hcl</i>)	Non Preferred	PA
MARPLAN ORAL TABLET 10 MG (<i>isocarboxazid</i>)	Non Preferred	PA
NARDIL ORAL TABLET 15 MG (<i>phenelzine sulfate</i>)	Non Preferred	PA
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG (<i>desvenlafaxine succinate</i>)	Non Preferred	PA
REMERON ORAL TABLET 15 MG, 30 MG (<i>mirtazapine</i>)	Non Preferred	PA
REMERON SOLTAB ORAL TABLET DISPERSIBLE 15 MG, 30 MG, 45 MG (<i>mirtazapine</i>)	Non Preferred	PA
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (<i>vortioxetine hbr</i>)	Non Preferred	PA
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (<i>vilazodone hcl</i>)	Non Preferred	PA
WELLBUTRIN SR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG (<i>bupropion hcl</i>)	Non Preferred	PA
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG (<i>bupropion hcl</i>)	Non Preferred	PA
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (<i>zuranolone</i>)	Non Preferred	PA; QL (28 EA per 1 Fill); AGE (Min 18 Years)
ZURZUVAE ORAL CAPSULE 30 MG (<i>zuranolone</i>)	Non Preferred	PA; QL (14 EA per 1 Fill); AGE (Min 18 Years)
ANTIDEPRESSANTS: SSRI [OPEN CLASS]		
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>escitalopram oxalate oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>escitalopram oxalate oral tablet 20 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1- month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sertraline hcl oral concentrate 20 mg/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>citalopram hydrobromide oral capsule 30 mg</i>	Non Preferred	PA
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	Non Preferred	PA
<i>fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg</i>	Non Preferred	PA
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	Non Preferred	PA
<i>fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg</i>	Non Preferred	PA
<i>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	Non Preferred	PA
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	Non Preferred	PA
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	Non Preferred	PA
<i>paroxetine mesylate oral capsule 7.5 mg</i>	Non Preferred	PA
<i>sertraline hcl oral capsule 150 mg, 200 mg</i>	Non Preferred	PA
CELEXA ORAL TABLET 10 MG, 20 MG, 40 MG (<i>citalopram hydrobromide</i>)	Non Preferred	PA
LEXAPRO ORAL TABLET 10 MG, 5 MG (<i>escitalopram oxalate</i>)	Non Preferred	PA
LEXAPRO ORAL TABLET 20 MG (<i>escitalopram oxalate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG (<i>paroxetine hcl</i>)	Non Preferred	PA
PAXIL ORAL SUSPENSION 10 MG/5ML (<i>paroxetine hcl</i>)	Non Preferred	PA
PAXIL ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG (<i>paroxetine hcl</i>)	Non Preferred	PA
PROZAC ORAL CAPSULE 10 MG, 20 MG, 40 MG (<i>fluoxetine hcl</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ZOLOFT ORAL CONCENTRATE 20 MG/ML (<i>sertraline hcl</i>)	Non Preferred	PA
ZOLOFT ORAL TABLET 100 MG, 25 MG, 50 MG (<i>sertraline hcl</i>)	Non Preferred	PA
ANTIEMETIC/ANTIVERTIGO AGENTS [OPEN CLASS]		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	Preferred	PA
<i>ft motion sickness oral tablet 25 mg, 50 mg</i>	Preferred	
<i>gnp motion sickness relief oral tablet 25 mg, 50 mg</i>	Preferred	
<i>hm motion sickness oral tablet 50 mg</i>	Preferred	
<i>hm motion sickness relief oral tablet 25 mg</i>	Preferred	
<i>meclizine hcl oral tablet 25 mg, 50 mg</i>	Preferred	
<i>meclizine hcl oral tablet chewable 25 mg</i>	Preferred	
<i>meclizine hcl tablet 12.5 mg oral (otc)</i>	Preferred	
<i>meclizine hcl tablet 12.5 mg oral (rx)</i>	Preferred	
<i>metoclopramide hcl injection solution 5 mg/ml</i>	Preferred	
<i>metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml</i>	Preferred	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	Preferred	
<i>motion sickness relief oral tablet 25 mg, 50 mg</i>	Preferred	
<i>motion-time oral tablet chewable 25 mg</i>	Preferred	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	Preferred	
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	Preferred	QL (60 EA per 1 Fill)
<i>ondansetron oral tablet dispersible 16 mg, 4 mg, 8 mg</i>	Preferred	QL (60 EA per 1 Fill)
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	Preferred	
<i>promethazine hcl injection solution 25 mg/ml, 50 mg/ml</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	Preferred	AGE (Min 2 Years)
<i>sm motion sickness oral tablet 25 mg, 50 mg</i>	Preferred	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	Preferred	
DICLEGIS ORAL TABLET DELAYED RELEASE 10-10 MG (<i>doxylamine-pyridoxine</i>)	Preferred	PA; AGE (Min 18 Years)
DRIMINATE ORAL TABLET 50 MG (<i>dimenhydrinate</i>)	Preferred	
<i>promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)</i>	Preferred	AGE (Min 2 Years)
<i>aprepitant oral 80 & 125 mg</i>	Non Preferred	PA; QL (1 EA per 1 Fill)
<i>aprepitant oral capsule 125 mg, 80 & 125 mg</i>	Non Preferred	PA; QL (1 EA per 1 Fill)
<i>aprepitant oral capsule 40 mg</i>	Non Preferred	PA; QL (4 EA per 1 Fill)
<i>aprepitant oral capsule 80 mg</i>	Non Preferred	PA; QL (2 EA per 1 Fill)

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<i>dimenhydrinate injection solution 50 mg/ml</i>	Non Preferred	PA
<i>doxylamine-pyridoxine oral tablet delayed release 10-10 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>focinvez intravenous solution 150 mg/50ml</i>	Non Preferred	PA
<i>fosaprepitant dimeglumine intravenous solution reconstituted 150 mg</i>	Non Preferred	PA
<i>granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml</i>	Non Preferred	PA
<i>granisetron hcl oral tablet 1 mg</i>	Non Preferred	PA
<i>ondansetron hcl injection solution 4 mg/2ml, 40 mg/20ml</i>	Non Preferred	PA
<i>ondansetron hcl injection solution prefilled syringe 4 mg/2ml</i>	Non Preferred	PA
<i>palonosetron hcl intravenous solution 0.25 mg/2ml, 0.25 mg/5ml</i>	Non Preferred	PA
<i>palonosetron hcl intravenous solution prefilled syringe 0.25 mg/5ml</i>	Non Preferred	PA
<i>prochlorperazine edisylate injection solution 10 mg/2ml, 50 mg/10ml</i>	Non Preferred	PA; AGE (Min 2 Years)
<i>prochlorperazine rectal suppository 25 mg</i>	Non Preferred	PA
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	Non Preferred	PA
AKYNZEO (READY-TO-USE) INTRAVENOUS SOLUTION 235-0.25 MG/20ML (<i>fosnetupitant-palonosetron</i>)	Non Preferred	PA
AKYNZEO (TO-BE-DILUTED) INTRAVENOUS SOLUTION 235-0.25 MG/20ML (<i>fosnetupitant-palonosetron</i>)	Non Preferred	PA
AKYNZEO INTRAVENOUS SOLUTION RECONSTITUTED 235-0.25 MG (<i>fosnetupitant-palonosetron</i>)	Non Preferred	PA
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	Non Preferred	PA
ANTIVERT ORAL TABLET 50 MG (<i>meclizine hcl</i>)	Non Preferred	PA
ANTIVERT ORAL TABLET CHEWABLE 25 MG (<i>meclizine hcl</i>)	Non Preferred	PA
ANZEMET ORAL TABLET 50 MG (<i>dolasetron mesylate</i>)	Non Preferred	PA; QL (10 EA per 1 Fill)
APONVIE INTRAVENOUS EMULSION 32 MG/4.4ML (<i>aprepitant</i>)	Non Preferred	PA; QL (4.4 ML per 1 Fill)
BARHEMSYS INTRAVENOUS SOLUTION 10 MG/4ML, 5 MG/2ML (<i>amisulpride (antiemetic)</i>)	Non Preferred	PA
BONJESTA ORAL TABLET EXTENDED RELEASE 20-20 MG (<i>doxylamine-pyridoxine</i>)	Non Preferred	PA; AGE (Min 18 Years)

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CINVANTI INTRAVENOUS EMULSION 130 MG/18ML (<i>aprepitant</i>)	Non Preferred	PA; QL (36 ML per 1 Fill)
<i>prochlorperazine</i> (Compro Rectal Suppository 25 Mg)	Non Preferred	PA
EMEND INTRAVENOUS SOLUTION RECONSTITUTED 150 MG (<i>fosaprepitant dimeglumine</i>)	Non Preferred	PA
EMEND ORAL CAPSULE 80 MG (<i>aprepitant</i>)	Non Preferred	PA; QL (2 EA per 1 Fill)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (<i>aprepitant</i>)	Non Preferred	PA
EMEND TRI-PACK ORAL CAPSULE 80 & 125 MG (<i>aprepitant</i>)	Non Preferred	PA; QL (1 EA per 1 Fill)
GIMOTI NASAL SOLUTION 15 MG/ACT (<i>metoclopramide hcl</i>)	Non Preferred	PA
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (<i>dronabinol</i>)	Non Preferred	PA
PHENERGAN INJECTION SOLUTION 25 MG/ML, 50 MG/ML (<i>promethazine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
POSFREA INTRAVENOUS SOLUTION 0.25 MG/5ML (<i>palonosetron hcl</i>)	Non Preferred	PA
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
REGLAN ORAL TABLET 10 MG, 5 MG (<i>metoclopramide hcl</i>)	Non Preferred	PA
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR (<i>granisetron</i>)	Non Preferred	PA; QL (2 EA per 1 Fill)
SUSTOL SUBCUTANEOUS PREFILLED SYRINGE 10 MG/0.4ML (<i>granisetron</i>)	Non Preferred	PA
TIGAN INTRAMUSCULAR SOLUTION 100 MG/ML (<i>trimethobenzamide hcl</i>)	Non Preferred	PA
TRANSDERM-SCOP TRANSDERMAL PATCH 72 HOUR 1 MG/3DAYS (<i>scopolamine base</i>)	Non Preferred	PA
ANTIFUNGALS: ORAL [OPEN CLASS]		
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>nystatin oral tablet 500000 unit</i>	Preferred	90-day fill allowed after two 1-month fills
<i>terbinafine hcl oral tablet 250 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>clotrimazole mouth/throat troche 10 mg</i>	Non Preferred	PA
<i>flucytosine oral capsule 250 mg, 500 mg</i>	Non Preferred	PA
<i>griseofulvin microsize oral tablet 500 mg</i>	Non Preferred	PA
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	Non Preferred	PA
<i>itraconazole oral capsule 100 mg</i>	Non Preferred	PA
<i>itraconazole oral solution 10 mg/ml</i>	Non Preferred	PA
<i>ketoconazole oral tablet 200 mg</i>	Non Preferred	PA
<i>posaconazole oral suspension 40 mg/ml</i>	Non Preferred	PA
<i>posaconazole oral tablet delayed release 100 mg</i>	Non Preferred	PA
<i>tolsura oral capsule 65 mg</i>	Non Preferred	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	Non Preferred	PA
<i>voriconazole oral tablet 200 mg, 50 mg</i>	Non Preferred	PA
ANCOBON ORAL CAPSULE 250 MG, 500 MG (<i>flucytosine</i>)	Non Preferred	PA
BREXAFEMME ORAL TABLET 150 MG (<i>ibrexafungerp citrate</i>)	Non Preferred	PA
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (<i>isavuconazonium sulfate</i>)	Non Preferred	PA
DIFLUCAN ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>fluconazole</i>)	Non Preferred	PA
DIFLUCAN ORAL TABLET 100 MG, 200 MG (<i>fluconazole</i>)	Non Preferred	PA
NOXAFIL ORAL PACKET 300 MG (<i>posaconazole</i>)	Non Preferred	PA; AGE (Max 16 Years)
NOXAFIL ORAL SUSPENSION 40 MG/ML (<i>posaconazole</i>)	Non Preferred	PA
NOXAFIL ORAL TABLET DELAYED RELEASE 100 MG (<i>posaconazole</i>)	Non Preferred	PA
ORAVIG BUCCAL TABLET 50 MG (<i>miconazole</i>)	Non Preferred	PA
SPORANOX ORAL CAPSULE 100 MG (<i>itraconazole</i>)	Non Preferred	PA
SPORANOX ORAL SOLUTION 10 MG/ML (<i>itraconazole</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>voriconazole</i>)	Non Preferred	PA
VFEND ORAL TABLET 200 MG, 50 MG (<i>voriconazole</i>)	Non Preferred	PA
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (<i>oteseconazole</i>)	Non Preferred	PA
ANTIFUNGALS: TOPICAL [OPEN CLASS]		
<i>antifungal (clotrimazole) external cream 1 %</i>	Preferred	
<i>antifungal clotrimazole external cream 1 %</i>	Preferred	
<i>antifungal external cream 2 %</i>	Preferred	
<i>athletes foot (clotrimazole) external cream 1 %</i>	Preferred	
<i>athletes foot (terbinafine) external cream 1 %</i>	Preferred	
<i>ciclopirox external solution 8 %</i>	Preferred	
<i>clotrimazole anti-fungal external cream 1 %</i>	Preferred	
<i>clotrimazole cream 1 % external (otc)</i>	Preferred	
<i>clotrimazole cream 1 % external (rx)</i>	Preferred	
<i>clotrimazole solution 1 % external (otc)</i>	Preferred	
<i>clotrimazole solution 1 % external (rx)</i>	Preferred	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	Preferred	
<i>ft antifungal external cream 1 %, 2 %</i>	Preferred	
<i>ft athletes foot (clotrimaz) external cream 1 %</i>	Preferred	
<i>ft athletes foot (terbinafine) external cream 1 %</i>	Preferred	
<i>gnp athletes foot external cream 1 %</i>	Preferred	
<i>gnp terbinafine hydrochloride external cream 1 %</i>	Preferred	
<i>gnp tolnaftate external cream 1 %</i>	Preferred	
<i>ketoconazole external cream 2 %</i>	Preferred	
<i>ketoconazole external shampoo 2 %</i>	Preferred	
<i>miconazole nitrate external cream 2 %</i>	Preferred	
<i>nystatin external cream 100000 unit/gm</i>	Preferred	
<i>nystatin external ointment 100000 unit/gm</i>	Preferred	
<i>nystatin external powder 100000 unit/gm</i>	Preferred	
<i>sm antifungal clotrimazole external cream 1 %</i>	Preferred	
<i>sm antifungal miconazole external cream 2 %</i>	Preferred	
<i>sm antifungal tolnaftate external cream 1 %</i>	Preferred	
<i>sm athletes foot external cream 1 %</i>	Preferred	
<i>terbinafine hcl external cream 1 %</i>	Preferred	
<i>tm-clotrimazole external cream 1 %</i>	Preferred	
<i>tolnaftate external cream 1 %</i>	Preferred	
<i>tolnaftate external powder 1 %</i>	Preferred	
<i>ciclopirox (Ciclodan External Solution 8 %)</i>	Preferred	
MICOTRIN AC EXTERNAL CREAM 1 % (<i>clotrimazole</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MYCOZYL AC EXTERNAL CREAM 1 % (<i>clotrimazole</i>)	Preferred	
<i>nystatin</i> (Nyamyc External Powder 100000 Unit/Gm)	Preferred	
<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	Preferred	
TRIMAZOLE EXTERNAL CREAM 1 % (<i>clotrimazole</i>)	Preferred	
TRITOLNACIDE C EXTERNAL CREAM 1 % (<i>tolnaftate</i>)	Preferred	
<i>alevazol external ointment 1 %</i>	Non Preferred	PA
<i>antifungal external powder 2 %</i>	Non Preferred	PA
<i>antifungal maximum strength external solution 1 %</i>	Non Preferred	PA
<i>athletes foot powder spray external aerosol powder 1 %, 2 %</i>	Non Preferred	PA
<i>bensal hp external ointment 3 %</i>	Non Preferred	PA
<i>butenafine hcl external cream 1 %</i>	Non Preferred	PA
<i>ciclopirox external gel 0.77 %</i>	Non Preferred	PA
<i>ciclopirox external shampoo 1 %</i>	Non Preferred	PA
<i>ciclopirox olamine external cream 0.77 %</i>	Non Preferred	PA
<i>ciclopirox olamine external suspension 0.77 %</i>	Non Preferred	PA
<i>ciclopirox treatment external kit 8 %</i>	Non Preferred	PA
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	Non Preferred	PA
<i>econazole nitrate external cream 1 %</i>	Non Preferred	PA
<i>gnp miconazorb af external powder 2 %</i>	Non Preferred	PA
<i>ketoconazole external foam 2 %</i>	Non Preferred	PA
<i>luliconazole external cream 1 %</i>	Non Preferred	PA
<i>miconazole nitrate external solution 2 %</i>	Non Preferred	PA
<i>miconazole-zinc oxide-petrolat external ointment 0.25-15-81.35 %</i>	Non Preferred	PA; AGE (Max 16 Years)
<i>miconi-al external solution 2 %</i>	Non Preferred	PA
<i>naftifine hcl external cream 1 %, 2 %</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>naftifine hcl external gel 2 %</i>	Non Preferred	PA
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	Non Preferred	PA
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	Non Preferred	PA
<i>oxiconazole nitrate external cream 1 %</i>	Non Preferred	PA
<i>tavaborole external solution 5 %</i>	Non Preferred	PA
<i>tm-tolnaftate external solution 1 %</i>	Non Preferred	PA
<i>tm-tolnaftate lr external solution 1 %</i>	Non Preferred	PA
<i>tolnafi-al external solution 1 %</i>	Non Preferred	PA
<i>votriza-al external lotion 1 %</i>	Non Preferred	PA
ERTACZO EXTERNAL CREAM 2 % (<i>sertaconazole nitrate</i>)	Non Preferred	PA
EXTINA EXTERNAL FOAM 2 % (<i>ketconazole</i>)	Non Preferred	PA
FUNGOID TINCTURE EXTERNAL SOLUTION 2 % (<i>miconazole nitrate</i>)	Non Preferred	PA
JUBLIA EXTERNAL SOLUTION 10 % (<i>efinaconazole</i>)	Non Preferred	PA
<i>ketconazole</i> (Ketodan External Foam 2 %)	Non Preferred	PA
KETODAN EXTERNAL KIT 2 % (<i>ketconazole-cleanser</i>)	Non Preferred	PA
LOPROX EXTERNAL CREAM 0.77 % (<i>ciclopirox olamine</i>)	Non Preferred	PA
LOPROX EXTERNAL KIT 0.77 %, 0.77 % (SUSP) (<i>ciclopirox olamine-cleanser</i>)	Non Preferred	PA
LOPROX EXTERNAL SUSPENSION 0.77 % (<i>ciclopirox olamine</i>)	Non Preferred	PA
LUZU EXTERNAL CREAM 1 % (<i>luliconazole</i>)	Non Preferred	PA
MICOMITIN EXTERNAL SOLUTION 1 % (<i>tolnaftate</i>)	Non Preferred	PA
MICOTRIN AL EXTERNAL SOLUTION 1 % (<i>tolnaftate</i>)	Non Preferred	PA
MICOTRIN AP EXTERNAL POWDER 2 % (<i>miconazole nitrate</i>)	Non Preferred	PA
MYCOZYL AL EXTERNAL SOLUTION 1 % (<i>tolnaftate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MYCOZYL AP EXTERNAL POWDER 2 % (<i>miconazole nitrate</i>)	Non Preferred	PA
NAFTIN EXTERNAL GEL 1 %, 2 % (<i>naftifine hcl</i>)	Non Preferred	PA
OXISTAT EXTERNAL LOTION 1 % (<i>oxiconazole nitrate</i>)	Non Preferred	PA
TRITOLNACIDE S EXTERNAL SOLUTION 1 % (<i>tolnaftate</i>)	Non Preferred	PA
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (<i>miconazole-zinc oxide-petrolat</i>)	Non Preferred	PA; AGE (Max 16 Years)
ANTIHYPERTENSIVES: ANGIOTENSIN MODULATOR COMBINATIONS [OPEN CLASS]		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	Non Preferred	PA
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	Non Preferred	PA
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	Non Preferred	PA
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	Non Preferred	PA
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG (<i>amlodipine-olmesartan</i>)	Non Preferred	PA
EXFORGE HCT ORAL TABLET 10-160-12.5 MG, 10-160-25 MG, 10-320-25 MG, 5-160-12.5 MG, 5-160-25 MG (<i>amlodipine-valsartan-hctz</i>)	Non Preferred	PA
EXFORGE ORAL TABLET 10-160 MG, 10-320 MG, 5-160 MG, 5-320 MG (<i>amlodipine besylate-valsartan</i>)	Non Preferred	PA
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (<i>amlodipine besy-benazepril hcl</i>)	Non Preferred	PA
TEKTURNA HCT ORAL TABLET 300-12.5 MG, 300-25 MG (<i>aliskiren-hydrochlorothiazide</i>)	Non Preferred	PA
TEKTURNA ORAL TABLET 150 MG, 300 MG (<i>aliskiren fumarate</i>)	Non Preferred	PA
TRIBENZOR ORAL TABLET 20-5-12.5 MG, 40-10-12.5 MG, 40-10-25 MG, 40-5-12.5 MG, 40-5-25 MG (<i>olmesartan-amlodipine-hctz</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ANTIHYPERTENSIVES: ANGIOTENSIN MODULATORS [OPEN CLASS]		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	Preferred	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	Preferred	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (sacubitril-valsartan)	Preferred	QL (2 EA per 1 day)
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Non Preferred	PA
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	Non Preferred	PA
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	Non Preferred	PA
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>enalapril maleate oral solution 1 mg/ml</i>	Non Preferred	PA
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	Non Preferred	PA
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	Non Preferred	PA
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	Non Preferred	PA
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Non Preferred	PA
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	Non Preferred	PA
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	Non Preferred	PA
<i>valsartan oral solution 4 mg/ml</i>	Non Preferred	PA
ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (<i>quinapril hcl</i>)	Non Preferred	PA
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (<i>quinapril-hydrochlorothiazide</i>)	Non Preferred	PA
ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG (<i>ramipril</i>)	Non Preferred	PA
ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (<i>candesartan cilexetil-hctz</i>)	Non Preferred	PA
ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (<i>candesartan cilexetil</i>)	Non Preferred	PA
AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (<i>irbesartan-hydrochlorothiazide</i>)	Non Preferred	PA
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG (<i>irbesartan</i>)	Non Preferred	PA
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG (<i>olmesartan medoxomil-hctz</i>)	Non Preferred	PA
BENICAR ORAL TABLET 20 MG, 40 MG, 5 MG (<i>olmesartan medoxomil</i>)	Non Preferred	PA
COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG (<i>losartan potassium</i>)	Non Preferred	PA
DIOVAN HCT ORAL TABLET 160-12.5 MG, 160-25 MG, 320-12.5 MG, 320-25 MG, 80-12.5 MG (<i>valsartan-hydrochlorothiazide</i>)	Non Preferred	PA
DIOVAN ORAL TABLET 160 MG, 320 MG, 40 MG, 80 MG (<i>valsartan</i>)	Non Preferred	PA
EDARBI ORAL TABLET 40 MG, 80 MG (<i>azilsartan medoxomil</i>)	Non Preferred	PA
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (<i>azilsartan-chlorthalidone</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
EPANED ORAL SOLUTION 1 MG/ML (<i>enalapril maleate</i>)	Non Preferred	PA
HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (<i>losartan potassium-hctz</i>)	Non Preferred	PA
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (<i>benazepril-hydrochlorothiazide</i>)	Non Preferred	PA
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (<i>benazepril hcl</i>)	Non Preferred	PA
MICARDIS HCT ORAL TABLET 40-12.5 MG, 80-12.5 MG, 80-25 MG (<i>telmisartan-hctz</i>)	Non Preferred	PA
MICARDIS ORAL TABLET 20 MG, 40 MG, 80 MG (<i>telmisartan</i>)	Non Preferred	PA
QBRELIS ORAL SOLUTION 1 MG/ML (<i>lisinopril</i>)	Non Preferred	PA
VASERETIC ORAL TABLET 10-25 MG (<i>enalapril-hydrochlorothiazide</i>)	Non Preferred	PA
VASOTEC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (<i>enalapril maleate</i>)	Non Preferred	PA
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (<i>lisinopril-hydrochlorothiazide</i>)	Non Preferred	PA
ZESTRIL ORAL TABLET 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG (<i>lisinopril</i>)	Non Preferred	PA
ANTIHYPERTENSIVES: BETA BLOCKERS [OPEN CLASS]		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	Preferred	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	Preferred	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	Preferred	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	Preferred	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>propranolol-hctz oral tablet 40-25 mg, 80-25 mg</i>	Preferred	
<i>sotalol hcl (af) oral tablet 120 mg</i>	Preferred	
<i>sotalol hcl (af) oral tablet 160 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sotalol hcl (Sorine Oral Tablet 120 Mg, 160 Mg, 240 Mg, 80 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	Non Preferred	PA
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	Non Preferred	PA
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	Non Preferred	PA
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Non Preferred	PA
<i>pindolol oral tablet 10 mg, 5 mg</i>	Non Preferred	PA
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	Non Preferred	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl af</i>)	Non Preferred	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG (<i>sotalol hcl</i>)	Non Preferred	PA
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (<i>nebivolol hcl</i>)	Non Preferred	PA
COREG CR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 40 MG, 80 MG (<i>carvedilol phosphate</i>)	Non Preferred	PA
COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (<i>carvedilol</i>)	Non Preferred	PA
CORGARD ORAL TABLET 20 MG, 40 MG (<i>nadolol</i>)	Non Preferred	PA
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (<i>propranolol hcl</i>)	Non Preferred	PA; AGE (Max 1 Years)
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (<i>propranolol hcl</i>)	Non Preferred	PA
INDERAL XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	Non Preferred	PA
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	Non Preferred	PA
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	Non Preferred	PA
LOPRESSOR ORAL TABLET 100 MG, 50 MG (<i>metoprolol tartrate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SOTYLIZE ORAL SOLUTION 5 MG/ML (<i>sotalol hcl</i>)	Non Preferred	PA
TENORETIC 100 ORAL TABLET 100-25 MG (<i>atenolol-chlorthalidone</i>)	Non Preferred	PA
TENORETIC 50 ORAL TABLET 50-25 MG (<i>atenolol-chlorthalidone</i>)	Non Preferred	PA
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG (<i>atenolol</i>)	Non Preferred	PA
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (<i>metoprolol succinate</i>)	Non Preferred	PA
ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (<i>bisoprolol-hydrochlorothiazide</i>)	Non Preferred	PA
ANTIHYPERTENSIVES: CALCIUM CHANNEL BLOCKERS [OPEN CLASS]		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	Preferred	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>nifedipine oral capsule 10 mg, 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	Preferred	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>diltiazem hcl er beads</i> (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Preferred	90-day fill allowed after two 1-month fills
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg</i>	Non Preferred	PA
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	Non Preferred	PA
<i>levamlodipine maleate oral tablet 2.5 mg, 5 mg</i>	Non Preferred	PA
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	Non Preferred	PA
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	Non Preferred	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	Non Preferred	PA
CARDIZEM CD ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG (<i>diltiazem hcl coated beads</i>)	Non Preferred	PA
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG (<i>diltiazem hcl</i>)	Non Preferred	PA
KATERZIA ORAL SUSPENSION 1 MG/ML (<i>amlodipine benzoate</i>)	Non Preferred	PA
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Non Preferred	PA
NORLIQVA ORAL SOLUTION 1 MG/ML (<i>amlodipine besylate</i>)	Non Preferred	PA
NORVASC ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>amlodipine besylate</i>)	Non Preferred	PA
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (<i>nifedipine</i>)	Non Preferred	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (<i>nisoldipine</i>)	Non Preferred	PA
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (<i>diltiazem hcl er beads</i>)	Non Preferred	PA
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (<i>verapamil hcl</i>)	Non Preferred	PA
ANTIHYPERTENSIVES: SYMPATHOLYTICS [OPEN CLASS]		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>methyldopa oral tablet 250 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>clonidine hcl er oral tablet extended release 24 hour 0.17 mg</i>	Non Preferred	PA
<i>methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg</i>	Non Preferred	PA
ANTIHYPERTENSIVES [OPEN CLASS]		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>colchicine oral capsule 0.6 mg</i>	Preferred	
<i>colchicine oral tablet 0.6 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>probenecid oral tablet 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>allopurinol oral tablet 200 mg</i>	Non Preferred	PA
<i>febuxostat oral tablet 40 mg, 80 mg</i>	Non Preferred	PA
COLCRYS ORAL TABLET 0.6 MG (<i>colchicine</i>)	Non Preferred	PA
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (<i>colchicine</i>)	Non Preferred	PA
MITIGARE ORAL CAPSULE 0.6 MG (<i>colchicine</i>)	Non Preferred	PA
ULORIC ORAL TABLET 40 MG, 80 MG (<i>febuxostat</i>)	Non Preferred	PA
ZYLOPRIM ORAL TABLET 100 MG (<i>allopurinol</i>)	Non Preferred	PA
ANTIMIGRAINE AGENTS [OPEN CLASS]		
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	Preferred	QL (12 EA per 1 Fill)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	Preferred	QL (12 EA per 1 Fill)
<i>sumatriptan nasal solution 20 mg/act, 5 mg/act</i>	Preferred	QL (6 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	Preferred	QL (9 EA per 1 Fill)
<i>sumatriptan succinate oral tablet 25 mg, 50 mg</i>	Preferred	QL (18 EA per 1 Fill)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml</i>	Preferred	QL (2 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	Preferred	QL (1 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml</i>	Preferred	QL (2 ML per 30 days)
IMITREX NASAL SOLUTION 20 MG/ACT, 5 MG/ACT (<i>sumatriptan</i>)	Preferred	QL (6 EA per 30 days)

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Drug Name	Formulary Status	Requirements/Limits
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>frovatriptan succinate oral tablet 2.5 mg</i>	Non Preferred	PA; QL (12 EA per 1 Fill)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	Non Preferred	PA; QL (9 EA per 1 Fill)
<i>sumatriptan-naproxen sodium oral tablet 85-500 mg</i>	Non Preferred	PA
<i>zolmitriptan nasal solution 2.5 mg</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>zolmitriptan nasal solution 5 mg</i>	Non Preferred	PA
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	Non Preferred	PA; QL (8 EA per 1 Fill)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	Non Preferred	PA; QL (8 EA per 1 Fill)
FROVA ORAL TABLET 2.5 MG (<i>frovatriptan succinate</i>)	Non Preferred	PA; QL (12 EA per 1 Fill)
IMITREX ORAL TABLET 100 MG (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (9 EA per 1 Fill)
IMITREX ORAL TABLET 25 MG, 50 MG (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (18 EA per 1 Fill)
IMITREX STATDOSE REFILL SUBCUTANEOUS SOLUTION CARTRIDGE 4 MG/0.5ML, 6 MG/0.5ML (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (2 ML per 30 days)
IMITREX STATDOSE SYSTEM SUBCUTANEOUS SOLUTION AUTO-INJECTOR 4 MG/0.5ML, 6 MG/0.5ML (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (2 ML per 30 days)
MAXALT ORAL TABLET 10 MG (<i>rizatriptan benzoate</i>)	Non Preferred	PA; QL (12 EA per 1 Fill)
MAXALT-MLT ORAL TABLET DISPERSIBLE 10 MG (<i>rizatriptan benzoate</i>)	Non Preferred	PA; QL (12 EA per 1 Fill)
RELPAK ORAL TABLET 20 MG, 40 MG (<i>eletriptan hydrobromide</i>)	Non Preferred	PA; QL (6 EA per 1 Fill)
TOSYMRA NASAL SOLUTION 10 MG/ACT (<i>sumatriptan</i>)	Non Preferred	PA; QL (6 EA per 30 days)
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (<i>sumatriptan succinate</i>)	Non Preferred	PA
ZOMIG NASAL SOLUTION 2.5 MG (<i>zolmitriptan</i>)	Non Preferred	PA; QL (6 EA per 1 Fill)
ZOMIG NASAL SOLUTION 5 MG (<i>zolmitriptan</i>)	Non Preferred	PA
<i>zolmitriptan (Zomig Oral Tablet 2.5 Mg, 5 Mg)</i>	Non Preferred	PA; QL (8 EA per 1 Fill)

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Drug Name	Formulary Status	Requirements/Limits
ANTIMIGRAINE AGENTS: OTHERS [CLOSED CLASS]		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (<i>erenumab-aooe</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 ML per 30 days); AGE (Min 18 Years)
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1.5 ML per 30 days); AGE (Min 18 Years)
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1.5 ML per 30 days); AGE (Min 18 Years)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (<i>galcanezumab-gnlm</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>galcanezumab-gnlm</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 ML per 30 days); AGE (Min 18 Years)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (<i>rimegepant sulfate</i>)	Preferred	PA (Eligible for auto-PA approval); QL (16 EA per 30 days); AGE (Min 18 Years)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (<i>atogepant</i>)	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
UBRELVY ORAL TABLET 100 MG, 50 MG (<i>ubrogepant</i>)	Preferred	PA (Eligible for auto-PA approval); QL (16 EA per 30 days); AGE (Min 18 Years)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>galcanezumab-gnlm</i>)	Non Preferred	PA; QL (1 ML per 30 days); AGE (Min 18 Years)
REYVOW ORAL TABLET 100 MG, 50 MG (<i>lasmiditan succinate</i>)	Non Preferred	PA; QL (8 EA per 30 days); AGE (Min 18 Years)
VYEPTI INTRAVENOUS SOLUTION 100 MG/ML (<i>eptinezumab-jjmr</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (<i>zavegepant hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: ATYPICAL [CLOSED CLASS]		
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 18 Years)
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>lurasidone hcl oral tablet 80 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>olanzapine intramuscular solution reconstituted 10 mg</i>	Preferred	AGE (Min 18 Years)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>quetiapine fumarate oral tablet 150 mg</i>	Preferred	AGE (Min 18 Years)
<i>risperidone oral solution 1 mg/ml</i>	Preferred	QL (2 ML per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years)
<i>aripiprazole oral solution 1 mg/ml</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
<i>clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (<i>lumateperone tosylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
CLOZARIL ORAL TABLET 100 MG, 25 MG (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG (<i>iloperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
GEODON INTRAMUSCULAR SOLUTION RECONSTITUTED 20 MG (<i>ziprasidone mesylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG (<i>ziprasidone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 3 MG, 6 MG, 9 MG (<i>paliperidone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LATUDA ORAL TABLET 80 MG (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (<i>olanzapine-samidorphane</i>)	Non Preferred	PA; AGE (Min 18 Years)
NUPLAZID ORAL CAPSULE 34 MG (<i>pimavanserin tartrate</i>)	Non Preferred	SP; PA; QL (2 EA per 1 day); AGE (Min 18 Years)
NUPLAZID ORAL TABLET 10 MG (<i>pimavanserin tartrate</i>)	Non Preferred	SP; PA; QL (2 EA per 1 day); AGE (Min 18 Years)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (<i>brexpiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL ORAL SOLUTION 1 MG/ML (<i>risperidone</i>)	Non Preferred	PA; QL (2 ML per 1 day); AGE (Min 18 Years)
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 2.5 MG, 5 MG (<i>asenapine maleate</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR (<i>asenapine</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG (<i>quetiapine fumarate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG, 400 MG, 50 MG (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years)
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (<i>olanzapine-fluoxetine hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
VERSACLOZ ORAL SUSPENSION 50 MG/ML (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA INTRAMUSCULAR SOLUTION RECONSTITUTED 10 MG (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG, 5 MG, 7.5 MG (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA ZYDIS ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 20 MG, 5 MG (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: ATYPICAL, LONG-ACTING INJECTABLE [CLOSED CLASS]		
ABILIFY ASIMTUFI INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML, 960 MG/3.2ML (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per 1 Fill
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per 1 Fill
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML, 662 MG/2.4ML (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 42-day supply per 1 Fill
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years); Max 180-day supply per 1 Fill
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG (<i>risperidone</i>)	Preferred	AGE (Min 18 Years)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG (<i>risperidone microspheres</i>)	Preferred	QL (2 EA per 28 days); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML, 150 MG/0.42ML, 200 MG/0.56ML, 250 MG/0.7ML (<i>risperidone</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per 1 Fill
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML, 50 MG/0.14ML, 75 MG/0.21ML (<i>risperidone</i>)	Preferred	AGE (Min 18 Years)
<i>risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Non Preferred	PA; QL (2 EA per 28 days); AGE (Min 18 Years)
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 28 days); AGE (Min 18 Years)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG, 405 MG (<i>olanzapine pamoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: TYPICAL [CLOSED CLASS]		
<i>chlorpromazine hcl injection solution 25 mg/ml, 50 mg/2ml</i>	Preferred	AGE (Min 18 Years)
<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	Preferred	AGE (Min 18 Years)
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	Preferred	AGE (Min 18 Years)
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>haloperidol lactate injection solution 5 mg/ml</i>	Preferred	AGE (Min 18 Years)
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>pimozide oral tablet 1 mg, 2 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (<i>loxapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/ML (<i>haloperidol decanoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
BENIGN PROSTATIC HYPERTROPHY (BPH) [OPEN CLASS]		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>dutasteride oral capsule 0.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>finasteride oral tablet 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>tamsulosin hcl oral capsule 0.4 mg</i>	Preferred	90-day fill allowed after two 1-month fills
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (<i>benralizumab</i>)	Preferred	SP; PA; AGE (Min 6 Years)
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	Non Preferred	PA
<i>silodosin oral capsule 4 mg, 8 mg</i>	Non Preferred	PA
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
AVODART ORAL CAPSULE 0.5 MG (<i>dutasteride</i>)	Non Preferred	PA
CIALIS ORAL TABLET 5 MG (<i>tadalafil</i>)	Non Preferred	PA; AGE (Min 18 Years)
ENTADFI ORAL CAPSULE 5-5 MG (<i>finasteride-tadalafil</i>)	Non Preferred	PA; AGE (Min 18 Years)
FLOMAX ORAL CAPSULE 0.4 MG (<i>tamsulosin hcl</i>)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
PROSCAR ORAL TABLET 5 MG (<i>finasteride</i>)	Non Preferred	PA
RAPAFLO ORAL CAPSULE 4 MG, 8 MG (<i>silodosin</i>)	Non Preferred	PA
BILE SALTS [OPEN CLASS]		
<i>ursodiol oral capsule 300 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ursodiol oral tablet 250 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ursodiol oral tablet 500 mg</i>	Preferred	
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (<i>odevixibat</i>)	Non Preferred	SP; PA; QL (36 EA per 1 day)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (<i>odevixibat</i>)	Non Preferred	SP; PA; QL (12 EA per 1 day)
BYLVAY ORAL CAPSULE 1200 MCG (<i>odevixibat</i>)	Non Preferred	SP; PA; QL (6 EA per 1 day)
BYLVAY ORAL CAPSULE 400 MCG (<i>odevixibat</i>)	Non Preferred	SP; PA; QL (18 EA per 1 day)
CHENODAL ORAL TABLET 250 MG (<i>chenodiol</i>)	Non Preferred	SP; PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (<i>cholic acid</i>)	Non Preferred	SP; PA
IQIRVO ORAL TABLET 80 MG (<i>elafibranor</i>)	Non Preferred	PA
LIVMARLI ORAL SOLUTION 19 MG/ML (<i>maralixibat chloride</i>)	Non Preferred	PA
LIVMARLI ORAL SOLUTION 9.5 MG/ML (<i>maralixibat chloride</i>)	Non Preferred	SP; PA
OCALIVA ORAL TABLET 10 MG, 5 MG (<i>obeticholic acid</i>)	Non Preferred	SP; PA
RELTONE ORAL CAPSULE 200 MG, 400 MG (<i>ursodiol</i>)	Non Preferred	PA
URSO 250 ORAL TABLET 250 MG (<i>ursodiol</i>)	Non Preferred	PA
URSO FORTE ORAL TABLET 500 MG (<i>ursodiol</i>)	Non Preferred	PA
BONE RESORPTION SUPPRESSION: BISPHOSPHONATES [OPEN CLASS]		
<i>alendronate sodium oral tablet 10 mg, 35 mg, 70 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ibandronate sodium oral tablet 150 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>alendronate sodium oral solution 70 mg/75ml</i>	Non Preferred	PA
<i>risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>risedronate sodium oral tablet delayed release 35 mg</i>	Non Preferred	PA
ACTONEL ORAL TABLET 150 MG, 35 MG (<i>risedronate sodium</i>)	Non Preferred	PA
AELVIA ORAL TABLET DELAYED RELEASE 35 MG (<i>risedronate sodium</i>)	Non Preferred	PA
BINOSTO ORAL TABLET EFFERVESCENT 70 MG (<i>alendronate sodium</i>)	Non Preferred	PA
FOSAMAX ORAL TABLET 70 MG (<i>alendronate sodium</i>)	Non Preferred	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (<i>alendronate-cholecalciferol</i>)	Non Preferred	PA
BONE RESORPTION SUPPRESSION: CALCITONINS [OPEN CLASS]		
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	Preferred	90-day fill allowed after two 1-month fills
BONE RESORPTION SUPPRESSION: OTHER [OPEN CLASS]		
<i>raloxifene hcl oral tablet 60 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml</i>	Non Preferred	SP; PA
EVISTA ORAL TABLET 60 MG (<i>raloxifene hcl</i>)	Non Preferred	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	Non Preferred	SP; PA
BRONCHODILATORS: LONG ACTING BETA ADRENERGICS (LABA) [OPEN CLASS]		
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>salmeterol xinafoate</i>)	Preferred	90-day fill allowed after two 1-month fills
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>olodaterol hcl</i>)	Preferred	
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	Non Preferred	PA
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	Non Preferred	PA
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (<i>arformoterol tartrate</i>)	Non Preferred	PA
PERFORMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (<i>formoterol fumarate</i>)	Non Preferred	PA
BRONCHODILATORS: SHORT ACTING BETA ADRENERGIC [OPEN CLASS]		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	Preferred	90-day fill allowed after two 1-month fills
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%, 2.5 mg/0.5ml</i>	Preferred	
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (<i>albuterol sulfate</i>)	Preferred	90-day fill allowed after two 1-month fills
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (<i>albuterol sulfate</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	Non Preferred	PA
<i>levalbuterol tartrate inhalation aerosol 45 mcg/act</i>	Non Preferred	PA
PROAIR DIGIHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (<i>albuterol sulfate (sensor)</i>)	Non Preferred	PA
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (<i>levalbuterol tartrate</i>)	Non Preferred	PA
CEPHALOSPORINS: ORAL [OPEN CLASS]		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	Preferred	
<i>cefdinir oral capsule 300 mg</i>	Preferred	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	Preferred	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	Preferred	
<i>cefaclor er oral tablet extended release 12 hour 500 mg</i>	Non Preferred	PA
<i>cefaclor oral suspension reconstituted 125 mg/5ml, 375 mg/5ml</i>	Non Preferred	PA
<i>cefixime oral capsule 400 mg</i>	Non Preferred	PA
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	Non Preferred	PA
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	Non Preferred	PA
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	Non Preferred	PA
COLONY STIMULATING FACTORS [CLOSED CLASS]		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-jmdb</i>)	Preferred	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim</i>)	Preferred	
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim</i>)	Preferred	
<i>releuko injection solution 480 mcg/1.6ml</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>releuko subcutaneous solution prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml</i>	Non Preferred	PA
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-pbbk</i>)	Non Preferred	PA
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>tbo-filgrastim</i>)	Non Preferred	PA
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>tbo-filgrastim</i>)	Non Preferred	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (<i>sargramostim</i>)	Non Preferred	PA
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML (<i>pegfilgrastim</i>)	Non Preferred	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim</i>)	Non Preferred	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim-aafi</i>)	Non Preferred	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-aafi</i>)	Non Preferred	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-apgf</i>)	Non Preferred	PA
RELEUKO INJECTION SOLUTION 300 MCG/ML (<i>filgrastim-ayow</i>)	Non Preferred	PA
ROLVEDON SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 13.2 MG/0.6ML (<i>eflapegrastim-xnst</i>)	Non Preferred	PA
STIMUFEND SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-fpgk</i>)	Non Preferred	PA
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	Non Preferred	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	Non Preferred	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	Non Preferred	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	Non Preferred	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-bmez</i>)	Non Preferred	PA
CONTRACEPTIVES: LONG-ACTING IUDS & INJECTABLES [OPEN CLASS]		
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	Preferred	Max 365-day supply per 1 Fill
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	Preferred	Max 365-day supply per 1 Fill
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	Preferred	Max 365-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per 1 Fill
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per 1 Fill
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per 1 Fill
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (<i>etonogestrel</i>)	Preferred	Max 365-day supply per 1 Fill
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (<i>copper</i>)	Preferred	Max 365-day supply per 1 Fill
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per 1 Fill
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA; Max 365-day supply per 1 Fill
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA; Max 365-day supply per 1 Fill
COPD: BRONCHODILATORS AND PHOSPHODIESTERASE 4 (PDE4) INHIBITORS [CLOSED CLASS]		
<i>ipratropium bromide inhalation solution 0.02 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	Preferred	PA; AGE (Min 18 Years)
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (<i>umeclidinium-vilanterol</i>)	Preferred	90-day fill allowed after two 1-month fills
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	Preferred	90-day fill allowed after two 1-month fills
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	Preferred	90-day fill allowed after two 1-month fills
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (<i>tiotropium bromide monohydrate</i>)	Preferred	90-day fill allowed after two 1-month fills
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (<i>tiotropium bromide monohydrate</i>)	Preferred	90-day fill allowed after two 1-month fills
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	Non Preferred	PA
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	Non Preferred	PA
DALIRESP ORAL TABLET 250 MCG, 500 MCG (<i>roflumilast</i>)	Non Preferred	PA; AGE (Min 18 Years)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (<i>aclidinium br-formoterol fum</i>)	Non Preferred	PA; AGE (Min 18 Years)
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (<i>umeclidinium bromide</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT (<i>aclidinium bromide</i>)	Non Preferred	PA
YUPELRI INHALATION SOLUTION 175 MCG/3ML (<i>revfenacin</i>)	Non Preferred	PA
COUGH AND COLD [OPEN CLASS]		
<i>guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml</i>	Preferred	AGE (Min 18 Years)
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
<i>hydromet oral solution 5-1.5 mg/5ml</i>	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
HYCODAN ORAL SOLUTION 5-1.5 MG/5ML (<i>hydrocodone bit-homatrop mbr</i>)	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	Non Preferred	PA; AGE (Min 6 Years)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
<i>poly-tussin ac oral liquid 10-4-10 mg/5ml</i>	Non Preferred	PA; AGE (Min 6 Years)
<i>promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml</i>	Non Preferred	PA; AGE (Min 18 Years)
HISTEX-AC ORAL SYRUP 10-2.5-10 MG/5ML (<i>phenyleph-triprolidine-codeine</i>)	Non Preferred	PA; AGE (Min 6 Years)
HYCODAN ORAL TABLET 5-1.5 MG (<i>hydrocodone bit-homatrop mbr</i>)	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
MAR-COF CG EXPECTORANT ORAL LIQUID 225-7.5 MG/5ML (<i>guaifenesin-codeine</i>)	Non Preferred	PA; AGE (Min 18 Years)
NINJACOF-XG ORAL LIQUID 200-8 MG/5ML (<i>guaifenesin-codeine</i>)	Non Preferred	PA; AGE (Min 18 Years)
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (<i>chlorpheniramine-codeine</i>)	Non Preferred	PA; AGE (Min 6 Years)
CYTOKINE AND CAM ANTAGONISTS AND RELATED AGENTS [CLOSED CLASS]		
<i>infliximab intravenous solution reconstituted 100 mg</i>	Preferred	SP
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	Preferred	
<i>methotrexate sodium oral tablet 2.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	Preferred	SP; QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	Preferred	SP; QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (<i>etanercept</i>)	Preferred	SP; QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (<i>etanercept</i>)	Preferred	SP; QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	Preferred	SP; QL (8 ML per 34 days); AGE (Min 2 Years)
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab</i>)	Preferred	SP; AGE (Min 2 Years)
<i>adalimumab-aacf (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-aacf (2 syringe) subcutaneous prefilled syringe kit 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-aacf(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-aacf(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 80 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-adaz subcutaneous solution auto-injector 40 mg/0.4ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-adaz subcutaneous solution prefilled syringe 40 mg/0.4ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-adbm (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>adalimumab-adbm (2 syringe) subcutaneous prefilled syringe kit 10 mg/0.2ml, 20 mg/0.4ml, 40 mg/0.4ml, 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>adalimumab-ryvk (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
ABRILADA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab-afzb</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ABRILADA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab-afzb</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ABRILADA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-afzb</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	Non Preferred	SP; PA
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (<i>tocilizumab</i>)	Non Preferred	SP; PA
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	Non Preferred	SP; PA
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (<i>adalimumab-atto</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-atto</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (<i>adalimumab-atto</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 20 MG/0.4ML (<i>adalimumab-atto</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	Non Preferred	SP; PA
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	Non Preferred	SP; PA
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (<i>bimekizumab-bkzx</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (<i>bimekizumab-bkzx</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (<i>abrocitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (<i>certolizumab pegol</i>)	Non Preferred	SP; PA

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Drug Name	Formulary Status	Requirements/Limits
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML (<i>certolizumab pegol</i>)	Non Preferred	SP; PA
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG (<i>certolizumab pegol</i>)	Non Preferred	SP; PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX INTRAVENOUS SOLUTION 125 MG/5ML (<i>secukinumab</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML (<i>secukinumab</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-adbm</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-adbm</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-adbm</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-adbm</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>satralizumab-mwge</i>)	Non Preferred	SP; PA
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (<i>vedolizumab</i>)	Non Preferred	SP; PA
ENTYVIO SUBCUTANEOUS SOLUTION PEN-INJECTOR 108 MG/0.68ML (<i>vedolizumab</i>)	Non Preferred	SP; PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HULIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab-fkjp</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HULIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-fkjp</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML (<i>adalimumab-adaz</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML, 20 MG/0.2ML, 40 MG/0.4ML (<i>adalimumab-adaz</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ-CROHNS/UC STARTER SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>adalimumab-adaz</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)

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Drug Name	Formulary Status	Requirements/Limits
HYRIMOZ-PED<40KG CROHN STARTER SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab-adaz</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ-PED>/=40KG CROHN START SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML (<i>adalimumab-adaz</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ-PLAQ PSOR/UEVIT START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab-adaz</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab-aacf</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (<i>adalimumab-aacf</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO-CROHNS/UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab-aacf</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO-PSORIASIS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (<i>adalimumab-aacf</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML (<i>canakinumab</i>)	Non Preferred	SP; PA
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>tildrakizumab-asmn</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	Non Preferred	SP; PA
JYLAMVO ORAL SOLUTION 2 MG/ML (<i>methotrexate</i>)	Non Preferred	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	Non Preferred	SP; PA
LITFULO ORAL CAPSULE 50 MG (<i>ritlecitinib tosylate</i>)	Non Preferred	PA; AGE (Min 12 Years)
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (<i>baricitinib</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
OMVOH INTRAVENOUS SOLUTION 300 MG/15ML (<i>mirikizumab-mrkz</i>)	Non Preferred	SP; PA; QL (45 ML per 84 days); AGE (Min 18 Years)
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mirikizumab-mrkz</i>)	Non Preferred	SP; PA; QL (2 ML per 28 days); AGE (Min 18 Years)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mirikizumab-mrkz</i>)	Non Preferred	SP; PA; QL (2 ML per 28 days); AGE (Min 18 Years)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (<i>abatacept</i>)	Non Preferred	SP; PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG (<i>abatacept</i>)	Non Preferred	SP; PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML (<i>abatacept</i>)	Non Preferred	SP; PA

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Drug Name	Formulary Status	Requirements/Limits
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	Non Preferred	PA
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	Non Preferred	SP; PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	Non Preferred	SP; PA
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	Non Preferred	PA
OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab</i>)	Non Preferred	SP; PA
RENFLXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	Non Preferred	SP; PA
RINVOQ LQ ORAL SOLUTION 1 MG/ML (<i>upadacitinib</i>)	Non Preferred	SP; PA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG (<i>upadacitinib</i>)	Non Preferred	SP; PA
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (<i>brodalumab</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (<i>golimumab</i>)	Non Preferred	SP; PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	Non Preferred	SP; PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	Non Preferred	SP; PA
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML (<i>risankizumab-rzaa</i>)	Non Preferred	SP; PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>risankizumab-rzaa</i>)	Non Preferred	SP; PA
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML (<i>risankizumab-rzaa</i>)	Non Preferred	SP; PA
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>risankizumab-rzaa</i>)	Non Preferred	SP; PA
SOTYKTU ORAL TABLET 6 MG (<i>deucravacitinib</i>)	Non Preferred	SP; PA

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Drug Name	Formulary Status	Requirements/Limits
SPEVIGO INTRAVENOUS SOLUTION 450 MG/7.5ML (<i>spesolimab-sbzo</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>spesolimab-sbzo</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
STELARA INTRAVENOUS SOLUTION 130 MG/26ML (<i>ustekinumab</i>)	Non Preferred	SP; PA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab</i>)	Non Preferred	SP; PA
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab</i>)	Non Preferred	SP; PA
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (<i>ixekizumab</i>)	Non Preferred	SP; PA
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML (<i>ixekizumab</i>)	Non Preferred	PA
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML (<i>ixekizumab</i>)	Non Preferred	SP; PA
TOFIDENCE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (<i>tocilizumab-bavi</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (<i>guselkumab</i>)	Non Preferred	SP; PA
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML (<i>guselkumab</i>)	Non Preferred	SP; PA
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (<i>methotrexate sodium</i>)	Non Preferred	PA
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (<i>tocilizumab-aazg</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
UPLIZNA INTRAVENOUS SOLUTION 100 MG/10ML (<i>inebilizumab-cdon</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
VELSIPITY ORAL TABLET 2 MG (<i>etrasimod arginine</i>)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 18 Years)
XATMEP ORAL SOLUTION 2.5 MG/ML (<i>methotrexate</i>)	Non Preferred	PA
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	Non Preferred	SP; PA
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	Non Preferred	SP; PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	Non Preferred	SP; PA
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML (<i>adalimumab-aaty</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
YUFLYMA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-aaty</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)

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Drug Name	Formulary Status	Requirements/Limits
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML (<i>adalimumab-aaty</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab-aaty</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
YUSIMRY SUBCUTANEOUS SOLUTION PEN-INJECTOR 40 MG/0.8ML (<i>adalimumab-aqvh</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ZYMFENTRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (<i>infliximab-dyyb</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZYMFENTRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (<i>infliximab-dyyb</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZYMFENTRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 120 MG/ML (<i>infliximab-dyyb</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: ALPHA-GLUCOSIDASE INHIBITORS [OPEN CLASS]		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
PRECOSE ORAL TABLET 100 MG, 25 MG, 50 MG (<i>acarbose</i>)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: BIGUANIDES (METFORMIN) [OPEN CLASS]		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	Preferred	AGE (Min 18 Years)
<i>glyburide-metformin oral tablet 1.25-250 mg, 5-500 mg</i>	Preferred	AGE (Min 18 Years)
<i>glyburide-metformin oral tablet 2.5-500 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	Preferred	AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	Preferred	AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
<i>metformin hcl er (mod) oral tablet extended release 24 hour 1000 mg, 500 mg</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg, 500 mg</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl oral solution 500 mg/5ml</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl oral tablet 625 mg</i>	Non Preferred	PA; AGE (Min 10 Years)
GLUMETZA ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 500 MG (<i>metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)
RIOMET ER ORAL SUSPENSION RECONSTITUTED ER 500 MG/5ML (<i>metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)

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Drug Name	Formulary Status	Requirements/Limits
RIOMET ORAL SOLUTION 500 MG/5ML (<i>metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)
DIABETES ORAL HYPOGLYCEMICS: DPP-IV INHIBITORS AND COMBINATIONS [CLOSED CLASS]		
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (<i>sitagliptin-metformin hcl</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (<i>sitagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (<i>sitagliptin phosphate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG, 5-500 MG (<i>saxagliptin-metformin</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
ONGLYZA ORAL TABLET 2.5 MG, 5 MG (<i>saxagliptin hcl</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
TRADJENTA ORAL TABLET 5 MG (<i>linagliptin</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>saxagliptin hcl oral tablet 2.5 mg, 5 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg, 5-1000 mg, 5-500 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>sitagliptin oral tablet 100 mg, 25 mg, 50 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
KAZANO ORAL TABLET 12.5-1000 MG, 12.5-500 MG (<i>alogliptin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
NESINA ORAL TABLET 12.5 MG, 25 MG, 6.25 MG (<i>alogliptin benzoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG (<i>alogliptin-pioglitazone</i>)	Non Preferred	PA; AGE (Min 18 Years)
QTERN ORAL TABLET 10-5 MG, 5-5 MG (<i>dapagliflozin-saxagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (<i>ertugliflozin-sitagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 12.5-2.5-1000 MG, 25-5-1000 MG, 5-2.5-1000 MG (<i>empagliflozin-linagliptin-metform</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (<i>sitagliptin</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: MEGLINITIDES [OPEN CLASS]		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
DIABETES ORAL HYPOGLYCEMICS: SECOND GENERATION SULFONYLUREAS [OPEN CLASS]		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>glimepiride oral tablet 3 mg</i>	Preferred	AGE (Min 18 Years)
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>glipizide oral tablet 10 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>glipizide oral tablet 2.5 mg</i>	Preferred	QL (16 EA per 1 day); AGE (Min 18 Years)
<i>glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 2.5 MG, 5 MG (<i>glipizide</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
GLYNASE ORAL TABLET 1.5 MG, 3 MG, 6 MG (<i>glyburide micronized</i>)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: SODIUM GLUCOSE CO-TRANSPORTER 2 INHIBITOR [CLOSED CLASS]		
FARXIGA ORAL TABLET 10 MG, 5 MG (<i>dapagliflozin propanediol</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JARDIANCE ORAL TABLET 10 MG, 25 MG (<i>empagliflozin</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	Preferred	AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	Preferred	AGE (Min 18 Years)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG (<i>dapagliflozin prop-metformin</i>)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg, 5-1000 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>dapagliflozin propanediol oral tablet 10 mg, 5 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>sitagliptin base-metformin hcl oral tablet 50-1000 mg, 50-500 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
INPEFA ORAL TABLET 200 MG, 400 MG (<i>sotagliflozin</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (<i>canagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (<i>canagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
INVOKANA ORAL TABLET 100 MG (<i>canagliflozin</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
INVOKANA ORAL TABLET 300 MG (<i>canagliflozin</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG (<i>ertugliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
STEGLATRO ORAL TABLET 15 MG, 5 MG (<i>ertugliflozin l-pyroglytamiticac</i>)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: THIAZOLIDINEDIONES [OPEN CLASS]		
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
ACTOPLUS MET ORAL TABLET 15-850 MG (<i>pioglitazone hcl-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
ACTOS ORAL TABLET 15 MG, 30 MG, 45 MG (<i>pioglitazone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (<i>pioglitazone hcl-glimepiride</i>)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES: INJECTABLE AMYLIN ANALOGS [CLOSED CLASS]		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML (<i>pramlintide acetate</i>)	Non Preferred	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML (<i>pramlintide acetate</i>)	Non Preferred	PA
DIABETES: INJECTABLE AND ORAL INCRETIN MIMETICS [CLOSED CLASS]		
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML (<i>exenatide</i>)	Preferred	PA (Eligible for auto-PA approval); QL (7.2 ML per 90 days); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML (<i>exenatide</i>)	Preferred	PA (Eligible for auto-PA approval); QL (3.6 ML per 90 days); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	Preferred	PA (Eligible for auto-PA approval); QL (6 ML per 84 days); AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide</i>)	Preferred	PA (Eligible for auto-PA approval); QL (27 ML per 90 days); AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML (<i>exenatide</i>)	Non Preferred	PA; QL (3.4 ML per 28 days); AGE (Min 10 Years)
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (<i>semaglutide</i>)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (<i>semaglutide</i>)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (<i>semaglutide</i>)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (<i>semaglutide</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (<i>insulin glargine-lixisenatide</i>)	Non Preferred	PA; AGE (Min 18 Years)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML (<i>insulin degludec-liraglutide</i>)	Non Preferred	PA; QL (15 ML per 28 days); AGE (Min 18 Years)
DUCHENNE MUSCULAR DYSTROPHY [CLOSED CLASS]		
<i>amondys 45 intravenous solution 100 mg/2ml</i>	Non Preferred	PA
AGAMREE ORAL SUSPENSION 40 MG/ML (<i>vamorolone</i>)	Non Preferred	PA; AGE (Min 2 Years)
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (<i>givinostat hcl</i>)	Non Preferred	PA; AGE (Min 6 Years)
EXONDYS 51 INTRAVENOUS SOLUTION 100 MG/2ML, 500 MG/10ML (<i>eteplirsen</i>)	Non Preferred	SP; PA
VILTEPSO INTRAVENOUS SOLUTION 250 MG/5ML (<i>viltolarsen</i>)	Non Preferred	SP; PA
VYONDYS 53 INTRAVENOUS SOLUTION 100 MG/2ML (<i>golodirsen</i>)	Non Preferred	SP; PA
EPINEPHRINE: SELF-INJECTED [OPEN CLASS]		
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	Preferred	QL (12 EA per 365 days)
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (<i>epinephrine</i>)	Preferred	QL (12 EA per 365 days)
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML (<i>epinephrine</i>)	Preferred	QL (12 EA per 365 days)
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml</i>	Non Preferred	PA; QL (12 EA per 365 days)
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)
SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)
ERYTHROPOIESIS STIMULATING PROTEINS [OPEN CLASS]		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (<i>epoetin alfa</i>)	Preferred	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 10000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 2000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
RETACRIT SOLUTION 20000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 3000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 4000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	Non Preferred	PA
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG, 8 MG (<i>daprodustat</i>)	Non Preferred	PA; AGE (Min 18 Years)
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 120 MCG/0.3ML, 150 MCG/0.3ML, 200 MCG/0.3ML, 30 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa</i>)	Non Preferred	PA
RETACRIT SOLUTION 10000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 2000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 20000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 3000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 4000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
GI ANTIBIOTICS [OPEN CLASS]		
<i>metronidazole oral tablet 250 mg, 500 mg</i>	Preferred	
<i>neomycin sulfate oral tablet 500 mg</i>	Preferred	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	Preferred	
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (<i>vancomycin hcl</i>)	Preferred	
<i>metronidazole oral capsule 375 mg</i>	Non Preferred	PA
<i>nitazoxanide oral tablet 500 mg</i>	Non Preferred	PA
<i>paromomycin sulfate oral capsule 250 mg</i>	Non Preferred	PA
<i>tinidazole oral tablet 250 mg, 500 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml</i>	Non Preferred	PA
AEMCOLO ORAL TABLET DELAYED RELEASE 194 MG (<i>rifamycin sodium</i>)	Non Preferred	PA
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>fidaxomicin</i>)	Non Preferred	PA; AGE (Max 16 Years)
DIFICID ORAL TABLET 200 MG (<i>fidaxomicin</i>)	Non Preferred	PA
FLAGYL ORAL CAPSULE 375 MG (<i>metronidazole</i>)	Non Preferred	PA
LIKMEZ ORAL SUSPENSION 500 MG/5ML (<i>metronidazole</i>)	Non Preferred	PA
SOLOSEC ORAL PACKET 2 GM (<i>secnidazole</i>)	Non Preferred	PA
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (<i>vancomycin hcl</i>)	Non Preferred	PA
VOWST ORAL CAPSULE (<i>fecal microb spores, live-brpk</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
XIFAXAN ORAL TABLET 200 MG (<i>rifaximin</i>)	Non Preferred	PA; AGE (Min 12 Years)
XIFAXAN ORAL TABLET 550 MG (<i>rifaximin</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
GI MOTILITY: CHRONIC [OPEN CLASS]		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	Preferred	PA; AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
LINZESS ORAL CAPSULE 145 MCG, 290 MCG (<i>linaclotide</i>)	Preferred	PA; AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
LINZESS ORAL CAPSULE 72 MCG (<i>linaclotide</i>)	Preferred	PA; AGE (Min 6 Years); 90-day fill allowed after two 1-month fills
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (<i>naloxegol oxalate</i>)	Preferred	PA; AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
<i>alosetron hcl oral tablet 0.5 mg, 1 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (<i>lubiprostone</i>)	Non Preferred	PA; AGE (Min 18 Years)
IBSRELA ORAL TABLET 50 MG (<i>tenapanor hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
LOTRONEX ORAL TABLET 0.5 MG, 1 MG (<i>alosetron hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
MOTEGRITY ORAL TABLET 1 MG, 2 MG (<i>prucalopride succinate</i>)	Non Preferred	PA; AGE (Min 18 Years)
RELISTOR ORAL TABLET 150 MG (<i>methylnaltrexone bromide</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	Non Preferred	PA; AGE (Min 18 Years)
SYMPROIC ORAL TABLET 0.2 MG (<i>naldemedine tosylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRULANCE ORAL TABLET 3 MG (<i>plecanatide</i>)	Non Preferred	PA; AGE (Min 18 Years)
VIBERZI ORAL TABLET 100 MG, 75 MG (<i>eluxadoline</i>)	Non Preferred	PA; AGE (Min 18 Years)
GLUCAGON AGENTS [CLOSED CLASS]		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	Preferred	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	Preferred	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (<i>diazoxide</i>)	Preferred	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	Preferred	
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (<i>dasiglucagon hcl</i>)	Preferred	
<i>diazoxide oral suspension 50 mg/ml</i>	Non Preferred	PA
<i>glucagon emergency injection kit 1 mg</i>	Non Preferred	PA
<i>glucagon emergency injection solution reconstituted 1 mg/ml</i>	Non Preferred	PA
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG (<i>glucagon hcl (rdna)</i>)	Non Preferred	PA
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (<i>glucagon</i>)	Non Preferred	PA
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (<i>glucagon</i>)	Non Preferred	PA
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (<i>glucagon</i>)	Non Preferred	PA
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (<i>glucagon</i>)	Non Preferred	PA
GLUCOCORTICOIDS: ORAL [OPEN CLASS]		
<i>budesonide oral capsule delayed release particles 3 mg</i>	Preferred	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	Preferred	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	Preferred	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	Preferred	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	Preferred	
<i>methylprednisolone oral tablet 4 mg</i>	Preferred	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	Preferred	
<i>prednisolone oral solution 15 mg/5ml</i>	Preferred	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>prednisone oral solution 5 mg/5ml</i>	Preferred	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	Preferred	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML (<i>dexamethasone</i>)	Preferred	
EMFLAZA ORAL SUSPENSION 22.75 MG/ML (<i>deflazacort</i>)	Preferred	SP; PA
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG (<i>deflazacort</i>)	Preferred	SP; PA
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML (<i>prednisone</i>)	Preferred	
<i>cortisone acetate oral tablet 25 mg</i>	Non Preferred	PA
<i>deflazacort oral suspension 22.75 mg/ml</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>deflazacort oral tablet 18 mg, 30 mg, 6 mg</i>	Non Preferred	SP; PA; AGE (Min 2 Years)
<i>dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)</i>	Non Preferred	PA
<i>methylprednisolone oral tablet 16 mg, 32 mg, 8 mg</i>	Non Preferred	PA
<i>prednisolone oral tablet 5 mg</i>	Non Preferred	PA
<i>prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml</i>	Non Preferred	PA
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg</i>	Non Preferred	PA
ALKINDI SPRINKLE ORAL CAPSULE SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG (<i>hydrocortisone</i>)	Non Preferred	SP; PA; AGE (Max 16 Years)
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (<i>hydrocortisone</i>)	Non Preferred	PA
EOHILIA ORAL SUSPENSION 2 MG/10ML (<i>budesonide</i>)	Non Preferred	PA; AGE (Min 11 Years)
HEMADY ORAL TABLET 20 MG (<i>dexamethasone</i>)	Non Preferred	PA
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG (<i>methylprednisolone</i>)	Non Preferred	PA
MEDROL ORAL TABLET THERAPY PACK 4 MG (<i>methylprednisolone</i>)	Non Preferred	PA
<i>prednisolone (Millipred Oral Tablet 5 Mg)</i>	Non Preferred	PA
RAYOS ORAL TABLET DELAYED RELEASE 1 MG, 2 MG, 5 MG (<i>prednisone</i>)	Non Preferred	PA
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (<i>dexamethasone</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>dexamethasone</i> (Taperdex 6-Day Oral Tablet Therapy Pack 1.5 Mg, 1.5 Mg (21))	Non Preferred	PA
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (<i>dexamethasone</i>)	Non Preferred	PA
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (<i>budesonide</i>)	Non Preferred	PA
GROWTH HORMONE [CLOSED CLASS]		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (<i>somatropin</i>)	Preferred	SP; PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (<i>somatropin</i>)	Preferred	SP; PA
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML (<i>somatropin</i>)	Preferred	SP; PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG (<i>somatropin</i>)	Non Preferred	SP; PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML (<i>somatrogon-ghla</i>)	Non Preferred	SP; PA; QL (4.8 ML per 28 days); AGE (Min 3 Years and Max 16 Years)
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (<i>somatropin</i>)	Non Preferred	SP; PA
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (<i>somatropin</i>)	Non Preferred	SP; PA
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (<i>somatropin</i>)	Non Preferred	SP; PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML (<i>somatropin</i>)	Non Preferred	SP; PA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (<i>somatropin</i>)	Non Preferred	SP; PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	Non Preferred	SP; PA
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	SP; PA; AGE (Min 1 Years and Max 16 Years)
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (<i>somapacitan-beco</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (<i>somatropin</i>)	Non Preferred	SP; PA
H. PYLORI TREATMENT [OPEN CLASS]		
PYLERA ORAL CAPSULE 140-125-125 MG (<i>bis subcit-metronid-tetracyc</i>)	Preferred	
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg</i>	Non Preferred	PA
<i>bis subcit-metronid-tetracyc oral capsule 140-125-125 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg</i>	Non Preferred	PA
OMECLAMOX-PAK ORAL 500-500-20 MG (<i>amoxicill-clarithro-omeprazole</i>)	Non Preferred	PA
TALICIA ORAL CAPSULE DELAYED RELEASE 250-12.5-10 MG (<i>amoxicill-rifabutin-omeprazole</i>)	Non Preferred	PA
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (<i>amoxicillin-vonoprazan</i>)	Non Preferred	PA; AGE (Min 18 Years)
VOQUEZNA ORAL TABLET 10 MG, 20 MG (<i>vonoprazan fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (<i>amoxicill-clarithro-vonoprazan</i>)	Non Preferred	PA; AGE (Min 18 Years)
HEMOPHILIA TREATMENT [CLOSED CLASS]		
<i>adynovate intravenous solution reconstituted 1000 unit, 1500 unit, 2000 unit, 250 unit, 3000 unit, 500 unit, 750 unit</i>	Preferred	SP
<i>obizur intravenous solution reconstituted 500 unit</i>	Preferred	SP
<i>rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit</i>	Preferred	SP
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	SP
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil fact single chain</i>)	Preferred	SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor-vwf</i>)	Preferred	SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (<i>coagulation factor ix</i>)	Preferred	SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>coagulation factor ix (rfixfc)</i>)	Preferred	SP
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	SP
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>coagulation factor ix (recomb)</i>)	Preferred	SP
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (<i>coagulation factor x (human)</i>)	Preferred	SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (<i>factor xiii concentrate human</i>)	Preferred	SP
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	SP

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Drug Name	Formulary Status	Requirements/Limits
ESPEROCT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (<i>antihemoph fact rcmb gpeg-exei</i>)	Preferred	SP
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (<i>antiinhibitor coagulant cplx</i>)	Preferred	SP
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (<i>emicizumab-kxwh</i>)	Preferred	SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor</i>)	Preferred	SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (<i>antihemophilic factor-vwf</i>)	Preferred	SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (<i>coagulation factor ix (rix-fp)</i>)	Preferred	SP
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>coagulation factor ix (recomb)</i>)	Preferred	SP
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (<i>ahf (bdd-rfviii peg-aucl)</i>)	Preferred	SP
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (<i>antihemophilic factor</i>)	Preferred	SP
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (<i>antihemophilic factor</i>)	Preferred	SP
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihem factor recomb (rfviii)</i>)	Preferred	SP
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	SP
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihemophil fact bd truncated</i>)	Preferred	SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (<i>coagulation factor viia recomb</i>)	Preferred	SP
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	SP
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (<i>factor ix complex</i>)	Preferred	SP
REBINYN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (<i>coagulation factor ix glycopeg</i>)	Preferred	SP

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Drug Name	Formulary Status	Requirements/Limits
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (<i>antihem factor recomb (rfviii)</i>)	Preferred	SP
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 5 MG (<i>coagulation factor viia-jncw</i>)	Preferred	SP
TRETEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (<i>coagulation factor xiii a-sub</i>)	Preferred	SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (<i>von willebrand factor (recomb)</i>)	Preferred	SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (<i>antihemophilic factor-vwf</i>)	Preferred	SP
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	SP
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	SP
HEPATITIS B [CLOSED CLASS]		
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 2 Years)
<i>adefovir dipivoxil oral tablet 10 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 12 Years)
<i>lamivudine oral tablet 100 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
BARACLUDE ORAL SOLUTION 0.05 MG/ML (<i>entecavir</i>)	Non Preferred	PA; QL (20 ML per 1 day); AGE (Min 2 Years)
BARACLUDE ORAL TABLET 0.5 MG, 1 MG (<i>entecavir</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 2 Years)
HEPSERA ORAL TABLET 10 MG (<i>adefovir dipivoxil</i>)	Non Preferred	PA
VEMLIDY ORAL TABLET 25 MG (<i>tenofovir alafenamide fumarate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years)
HEPATITIS C AGENTS [CLOSED CLASS]		
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	Preferred	SP; QL (Max 84 days of therapy per lifetime); AGE (Min 3 Years); Max 84-day supply per 1 Fill
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	Preferred	SP; QL (Max 84 days of therapy per lifetime); AGE (Min 3 Years); Max 84-day supply per 1 Fill
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	Preferred	SP; QL (Max 84 days of therapy per lifetime); AGE (Min 12 Years); Max 84-day supply per 1 Fill
<i>ledipasvir-sofosbuvir oral tablet 90-400 mg</i>	Non Preferred	SP; PA; AGE (Min 3 Years)

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Drug Name	Formulary Status	Requirements/Limits
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	SP; PA; AGE (Min 3 Years)
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	SP; PA; AGE (Min 3 Years)
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	SP; PA; QL (Max 84 days of therapy per lifetime); AGE (Min 3 Years); Max 84-day supply per 1 Fill
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	SP; PA; AGE (Min 3 Years and Max 16 Years)
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	SP; PA; AGE (Min 3 Years and Max 16 Years)
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	SP; PA; AGE (Min 3 Years)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	Non Preferred	SP; PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	Non Preferred	SP; PA
SOVALDI ORAL PACKET 150 MG, 200 MG (<i>sofosbuvir</i>)	Non Preferred	SP; PA; AGE (Max 16 Years)
SOVALDI ORAL TABLET 200 MG (<i>sofosbuvir</i>)	Non Preferred	SP; PA; AGE (Max 16 Years)
SOVALDI ORAL TABLET 400 MG (<i>sofosbuvir</i>)	Non Preferred	SP; PA
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasvir-voxilaprev</i>)	Non Preferred	SP; PA
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	Non Preferred	SP; PA
HEREDITARY ANGIOEDEMA (HAE) AGENTS [OPEN CLASS]		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	Preferred	SP; PA; AGE (Min 18 Years)
BERINERT INTRAVENOUS KIT 500 UNIT (<i>c1 esterase inhibitor (human)</i>)	Preferred	SP; PA; QL (4 EA per 1 Fill); AGE (Min 6 Years)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML (<i>ecallantide</i>)	Preferred	SP; PA; QL (6 ML per 1 Fill); AGE (Min 12 Years)
<i>icatibant acetate</i> (Sajazir Subcutaneous Solution Prefilled Syringe 30 Mg/3MI)	Preferred	SP; PA; AGE (Min 18 Years)
FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML (<i>icatibant acetate</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (<i>berotralstat hcl</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (<i>c1 esterase inhibitor (recomb)</i>)	Non Preferred	SP; PA; AGE (Min 13 Years)

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Drug Name	Formulary Status	Requirements/Limits
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (<i>Ianadelumab-flyo</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML (<i>Ianadelumab-flyo</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
HERPES: ORAL [OPEN CLASS]		
<i>acyclovir oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>acyclovir oral suspension 200 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>acyclovir oral tablet 400 mg, 800 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
SITAVIG BUCCAL TABLET 50 MG (<i>acyclovir</i>)	Non Preferred	PA
VALTRESX ORAL TABLET 1 GM, 500 MG (<i>valacyclovir hcl</i>)	Non Preferred	PA
HERPES: TOPICAL [OPEN CLASS]		
<i>acyclovir external cream 5 %</i>	Preferred	
<i>acyclovir external ointment 5 %</i>	Preferred	
<i>docosanol external cream 10 %</i>	Preferred	
<i>ft docosanol external cream 10 %</i>	Preferred	
<i>gnp docosanol external cream 10 %</i>	Preferred	
<i>penciclovir external cream 1 %</i>	Non Preferred	PA
DENAVIR EXTERNAL CREAM 1 % (<i>penciclovir</i>)	Non Preferred	PA
XERESE EXTERNAL CREAM 5-1 % (<i>acyclovir-hydrocortisone</i>)	Non Preferred	PA
ZOVIRAX EXTERNAL CREAM 5 % (<i>acyclovir</i>)	Non Preferred	PA
ZOVIRAX EXTERNAL OINTMENT 5 % (<i>acyclovir</i>)	Non Preferred	PA
HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2 RA) [OPEN CLASS]		
<i>acid reducer maximum strength oral tablet 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>acid reducer oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>famotidine maximum strength oral tablet 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug **PA** - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **RX** - Prescription Drug **SP** - Specialty Drug

Drug Name	Formulary Status	Requirements/Limits
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	Preferred	PA (Eligible for auto-PA approval); AGE (Max 11 Years); 90-day fill allowed after two 1-month fills
<i>famotidine oral tablet 10 mg, 40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>famotidine orig st oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>famotidine tablet 20 mg oral (otc)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>famotidine tablet 20 mg oral (rx)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft acid reducer max strength oral tablet 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft acid reducer oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp acid reducer max st oral tablet 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp acid reducer oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>heartburn relief max st oral tablet 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>heartburn relief oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm acid reducer max st oral tablet 20 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm acid reducer oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>acid reducer complete oral tablet chewable 10-800-165 mg</i>	Non Preferred	PA
<i>cimetidine hcl oral solution 300 mg/5ml</i>	Non Preferred	PA
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	Non Preferred	PA
<i>ft acid reducer + antacid oral tablet chewable 10-800-165 mg</i>	Non Preferred	PA
<i>goodsense dual action complete oral tablet chewable 10-800-165 mg</i>	Non Preferred	PA
<i>hm dual action complete oral tablet chewable 10-800-165 mg</i>	Non Preferred	PA
<i>nizatidine oral capsule 150 mg, 300 mg</i>	Non Preferred	PA
PEPCID ORAL TABLET 20 MG, 40 MG (<i>famotidine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
HIV/AIDS [CLOSED CLASS]		
<i>abacavir sulfate oral solution 20 mg/ml</i>	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
<i>abacavir sulfate oral tablet 300 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>atazanavir sulfate oral capsule 150 mg, 300 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>atazanavir sulfate oral capsule 200 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>darunavir oral tablet 600 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>darunavir oral tablet 800 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>efavirenz oral tablet 600 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>emtricitabine oral capsule 200 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>etravirine oral tablet 100 mg, 200 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>fosamprenavir calcium oral tablet 700 mg</i>	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>lamivudine oral solution 10 mg/ml</i>	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
<i>lamivudine oral tablet 150 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>lamivudine oral tablet 300 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	Preferred	QL (10 ML per 1 day); 90-day fill allowed after two 1-month fills
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	Preferred	QL (10 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>maraviroc oral tablet 150 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>maraviroc oral tablet 300 mg</i>	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>nevirapine er oral tablet extended release 24 hour 100 mg, 400 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>nevirapine oral suspension 50 mg/5ml</i>	Preferred	QL (40 ML per 1 day); 90-day fill allowed after two 1-month fills
<i>nevirapine oral tablet 200 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>ritonavir oral tablet 100 mg</i>	Preferred	QL (12 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>trimeq pd oral tablet soluble 60-5-30 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
<i>zidovudine oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>zidovudine oral syrup 50 mg/5ml</i>	Preferred	QL (60 ML per 1 day); 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>zidovudine oral tablet 300 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML (<i>cabotegravir</i>)	Preferred	QL (3 ML per 28 days); Max 56-day supply per 1 Fill
BIKTARVY ORAL TABLET 30-120-15 MG (<i>bictegravir-emtricitab-tenofof</i>)	Preferred	QL (1 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
BIKTARVY ORAL TABLET 50-200-25 MG (<i>bictegravir-emtricitab-tenofof</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML (<i>cabotegravir & rilpivirine</i>)	Preferred	QL (12 ML per 84 days); 90-day fill allowed after two 1-month fills
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML (<i>cabotegravir & rilpivirine</i>)	Preferred	QL (6 ML per 28 days); 90-day fill allowed after two 1-month fills
CIMDUO ORAL TABLET 300-300 MG (<i>lamivudine-tenofovir</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofovir</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofof df</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG (<i>emtricitabine-tenofovir af</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
EMTRIVA ORAL CAPSULE 200 MG (<i>emtricitabine</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
EMTRIVA ORAL SOLUTION 10 MG/ML (<i>emtricitabine</i>)	Preferred	QL (24 ML per 1 day); 90-day fill allowed after two 1-month fills
EPIVIR ORAL SOLUTION 10 MG/ML (<i>lamivudine</i>)	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (<i>enfuvirtide</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
INTELENCE ORAL TABLET 100 MG, 200 MG (<i>etravirine</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	Preferred	QL (2 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (<i>raltegravir potassium</i>)	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
LEXIVA ORAL TABLET 700 MG (<i>fosamprenavir calcium</i>)	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	Preferred	QL (12 EA per 1 day); 90-day fill allowed after two 1-month fills
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofov af</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
PIFELTRO ORAL TABLET 100 MG (<i>doravirine</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
PREZCOBIX ORAL TABLET 800-150 MG (<i>darunavir-cobicistat</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
RETROVIR ORAL CAPSULE 100 MG (<i>zidovudine</i>)	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 150 MG (<i>maraviroc</i>)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 25 MG (<i>maraviroc</i>)	Preferred	QL (8 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 300 MG (<i>maraviroc</i>)	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 75 MG (<i>maraviroc</i>)	Preferred	QL (2 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG (<i>lenacapavir sodium</i>)	Preferred	AGE (Min 18 Years)
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (<i>lenacapavir sodium</i>)	Preferred	AGE (Min 18 Years)
SYMFI LO ORAL TABLET 400-300-300 MG (<i>efavirenz-lamivudine-tenofovir</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
SYMFI ORAL TABLET 600-300-300 MG (<i>efavirenz-lamivudine-tenofovir</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
TIVICAY ORAL TABLET 10 MG, 25 MG (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
TIVICAY ORAL TABLET 50 MG (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivudine</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (<i>emtricitabine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
TRUVADA ORAL TABLET 200-300 MG (<i>emtricitabine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
TYBOST ORAL TABLET 150 MG (<i>cobicistat</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
VIREAD ORAL POWDER 40 MG/GM (<i>tenofovir disoproxil fumarate</i>)	Preferred	QL (1 GM per 1 day); 90-day fill allowed after two 1-month fills
ZIAGEN ORAL SOLUTION 20 MG/ML (<i>abacavir sulfate</i>)	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
<i>didanosine oral capsule delayed release 250 mg, 400 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>efavirenz oral capsule 200 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>efavirenz oral capsule 50 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>stavudine oral capsule 40 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
APTIVUS ORAL CAPSULE 250 MG (<i>tipranavir</i>)	Non Preferred	PA; QL (4 EA per 1 day)
ATRIPLA ORAL TABLET 600-200-300 MG (<i>efavirenz-emtricitabine-tenofovir df</i>)	Non Preferred	PA; QL (1 EA per 1 day)
COMBIVIR ORAL TABLET 150-300 MG (<i>lamivudine-zidovudine</i>)	Non Preferred	PA; QL (2 EA per 1 day)
EPIVIR ORAL TABLET 150 MG (<i>lamivudine</i>)	Non Preferred	PA; QL (2 EA per 1 day)
EPIVIR ORAL TABLET 300 MG (<i>lamivudine</i>)	Non Preferred	PA; QL (1 EA per 1 day)
EPZICOM ORAL TABLET 600-300 MG (<i>abacavir sulfate-lamivudine</i>)	Non Preferred	PA; QL (1 EA per 1 day)
KALETRA ORAL SOLUTION 400-100 MG/5ML (<i>lopinavir-ritonavir</i>)	Non Preferred	PA; QL (10 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
KALETRA ORAL TABLET 100-25 MG (<i>lopinavir-ritonavir</i>)	Non Preferred	PA; QL (10 EA per 1 day)
KALETRA ORAL TABLET 200-50 MG (<i>lopinavir-ritonavir</i>)	Non Preferred	PA; QL (4 EA per 1 day)
LEXIVA ORAL SUSPENSION 50 MG/ML (<i>fosamprenavir calcium</i>)	Non Preferred	PA; QL (56 ML per 1 day)
NORVIR ORAL TABLET 100 MG (<i>ritonavir</i>)	Non Preferred	PA; QL (12 EA per 1 day)
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	Non Preferred	PA; QL (12 ML per 1 day)
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG (<i>darunavir</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PREZISTA ORAL TABLET 800 MG (<i>darunavir</i>)	Non Preferred	PA; QL (1 EA per 1 day)
RETROVIR ORAL SYRUP 50 MG/5ML (<i>zidovudine</i>)	Non Preferred	PA; QL (60 ML per 1 day)
REYATAZ ORAL CAPSULE 200 MG (<i>atazanavir sulfate</i>)	Non Preferred	PA; QL (2 EA per 1 day)
REYATAZ ORAL CAPSULE 300 MG (<i>atazanavir sulfate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
TRIZIVIR ORAL TABLET 300-150-300 MG (<i>abacavir-lamivudine-zidovudine</i>)	Non Preferred	PA; QL (2 EA per 1 day)
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML (<i>ibalizumab-uiyk</i>)	Non Preferred	PA
VIRACEPT ORAL TABLET 250 MG (<i>nelfinavir mesylate</i>)	Non Preferred	PA; QL (10 EA per 1 day)
VIRACEPT ORAL TABLET 625 MG (<i>nelfinavir mesylate</i>)	Non Preferred	PA; QL (4 EA per 1 day)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG, 300 MG (<i>tenofovir disoproxil fumarate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
IMMUNOMODULATORS ATOPIC DERMATITIS [CLOSED CLASS]		
<i>tacrolimus external ointment 0.03 %</i>	Preferred	PA (Eligible for auto-PA approval); QL (30 GM per 30 days); AGE (Min 2 Years)
<i>tacrolimus external ointment 0.1 %</i>	Preferred	PA (Eligible for auto-PA approval); QL (30 GM per 30 days); AGE (Min 16 Years)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>tralokinumab-ldrm</i>)	Preferred	SP; PA; QL (4 ML per 28 days); AGE (Min 18 Years)
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	Preferred	SP; PA (Eligible for auto-PA approval)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>dupilumab</i>)	Preferred	SP; PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	Preferred	SP; PA (Eligible for auto-PA approval)

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Drug Name	Formulary Status	Requirements/Limits
ELIDEL EXTERNAL CREAM 1 % (<i>pimecrolimus</i>)	Preferred	PA (Eligible for auto-PA approval); QL (30 GM per 30 days); AGE (Min 2 Years)
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	Preferred	PA (Eligible for auto-PA approval); QL (300 GM per 365 days); AGE (Min 3 months)
<i>pimecrolimus external cream 1 %</i>	Non Preferred	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
OPZELURA EXTERNAL CREAM 1.5 % (<i>ruxolitinib phosphate</i>)	Non Preferred	PA; QL (240 GM per 30 days); AGE (Min 12 Years)
ZORYVE EXTERNAL FOAM 0.3 % (<i>roflumilast (antiseborrheic)</i>)	Non Preferred	PA; AGE (Min 6 Years)
IMMUNOMODULATORS: ASTHMA [CLOSED CLASS]		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (<i>benralizumab</i>)	Preferred	SP; PA; AGE (Min 6 Years)
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML (<i>benralizumab</i>)	Preferred	SP; PA; AGE (Min 6 Years)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	Preferred	SP; PA; AGE (Min 1 Years)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	Preferred	SP; PA; AGE (Min 1 Years)
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (<i>omalizumab</i>)	Preferred	SP; PA; AGE (Min 1 Years)
CINQAIR INTRAVENOUS SOLUTION 100 MG/10ML (<i>reslizumab</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	Non Preferred	SP; PA; AGE (Min 6 Years and Max 11 Years)
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG (<i>mepolizumab</i>)	Non Preferred	SP; PA; AGE (Min 6 Years)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	Non Preferred	SP; PA; AGE (Min 12 Years)
INFLUENZA [OPEN CLASS]		
<i>oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg</i>	Preferred	
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	Preferred	
<i>rimantadine hcl oral tablet 100 mg</i>	Non Preferred	PA
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (<i>zanamivir</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TAMIFLU ORAL CAPSULE 30 MG, 45 MG, 75 MG (<i>oseltamivir phosphate</i>)	Non Preferred	PA
TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML (<i>oseltamivir phosphate</i>)	Non Preferred	PA
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (<i>baloxavir marboxil</i>)	Non Preferred	PA
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (<i>baloxavir marboxil</i>)	Non Preferred	PA
INHALED CORTICOSTEROIDS: COMBINATIONS [CLOSED CLASS]		
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT (<i>fluticasone-salmeterol</i>)	Preferred	90-day fill allowed after two 1-month fills
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (<i>fluticasone-salmeterol</i>)	Preferred	90-day fill allowed after two 1-month fills
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (<i>mometasone furo-formoterol fum</i>)	Preferred	90-day fill allowed after two 1-month fills
DULERA INHALATION AEROSOL 50-5 MCG/ACT (<i>mometasone furo-formoterol fum</i>)	Preferred	AGE (Max 12 Years); 90-day fill allowed after two 1-month fills
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (<i>budesonide-formoterol fumarate</i>)	Preferred	90-day fill allowed after two 1-month fills
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	Preferred	90-day fill allowed after two 1-month fills
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	Preferred	
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	Non Preferred	PA
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	Non Preferred	PA
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	Non Preferred	PA
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act</i>	Non Preferred	PA
AIRDUO DIGIHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT (<i>fluticasone-salmeterol(sensor)</i>)	Non Preferred	PA
AIRDUO RESPICLICK 113/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT (<i>fluticasone-salmeterol</i>)	Non Preferred	PA
AIRDUO RESPICLICK 232/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT (<i>fluticasone-salmeterol</i>)	Non Preferred	PA
AIRDUO RESPICLICK 55/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT (<i>fluticasone-salmeterol</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (<i>albuterol-budesonide</i>)	Non Preferred	PA; AGE (Min 18 Years)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT (<i>fluticasone furoate-vilanterol</i>)	Non Preferred	PA
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (<i>fluticasone furoate-vilanterol</i>)	Non Preferred	PA; AGE (Max 11 Years)
<i>budesonide-formoterol fumarate</i> (Brey-na Inhalation Aerosol 160-4.5 Mcg/Act, 80-4.5 Mcg/Act)	Non Preferred	PA
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	Non Preferred	PA
<i>fluticasone-salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	Non Preferred	PA
INHALED CORTICOSTEROIDS: MDIS [CLOSED CLASS]		
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT, 80 MCG/ACT (<i>ciclesonide</i>)	Preferred	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (<i>fluticasone furoate</i>)	Preferred	90-day fill allowed after two 1-month fills
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>fluticasone furoate</i>)	Preferred	AGE (Max 11 Years); 90-day fill allowed after two 1-month fills
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>mometasone furoate</i>)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>mometasone furoate</i>)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT (<i>mometasone furoate</i>)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>mometasone furoate</i>)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT (<i>mometasone furoate</i>)	Preferred	
ASMANEX HFA INHALATION AEROSOL 50 MCG/ACT (<i>mometasone furoate</i>)	Preferred	AGE (Max 12 Years)
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 250 MCG/ACT, 50 MCG/ACT (<i>fluticasone propionate (inhal)</i>)	Preferred	90-day fill allowed after two 1-month fills
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT, 44 MCG/ACT (<i>fluticasone propionate hfa</i>)	Preferred	90-day fill allowed after two 1-month fills
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (<i>budesonide</i>)	Preferred	90-day fill allowed after two 1-month fills
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	Non Preferred	PA
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	Non Preferred	PA
ARMONAIR DIGIHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 113 MCG/ACT, 232 MCG/ACT, 55 MCG/ACT (<i>fluticasone propionate(sensor)</i>)	Non Preferred	PA
INHALED CORTICOSTEROIDS: NEBULIZER SOLUTION [CLOSED CLASS]		
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml</i>	Preferred	AGE (Max 8 Years); 90-day fill allowed after two 1-month fills
PULMICORT INHALATION SUSPENSION 0.25 MG/2ML, 0.5 MG/2ML, 1 MG/2ML (<i>budesonide</i>)	Non Preferred	PA; AGE (Max 8 Years)
INSULINS: INSULIN MIX [OPEN CLASS]		
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	Preferred	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i>	Non Preferred	PA
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	Non Preferred	PA
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Non Preferred	PA
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Non Preferred	PA
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Non Preferred	PA
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Non Preferred	PA
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA
INSULINS: INSULIN N [OPEN CLASS]		
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Non Preferred	PA
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Non Preferred	PA
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Non Preferred	PA
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Non Preferred	PA
INSULINS: INSULIN R [OPEN CLASS]		
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	Non Preferred	PA
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	Non Preferred	PA
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	Non Preferred	PA
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	Non Preferred	PA
INSULINS: LONG-ACTING [OPEN CLASS]		
<i>insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin glargine subcutaneous solution 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	Preferred	
<i>insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml</i>	Preferred	
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	Preferred	90-day fill allowed after two 1-month fills
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	Preferred	90-day fill allowed after two 1-month fills
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine</i>)	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin detemir</i>)	Preferred	90-day fill allowed after two 1-month fills
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin detemir</i>)	Preferred	90-day fill allowed after two 1-month fills
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine-aglr</i>)	Preferred	
<i>insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml</i>	Non Preferred	PA
<i>insulin degludec subcutaneous solution 100 unit/ml</i>	Non Preferred	PA
<i>insulin glargine max solostar subcutaneous solution pen-injector 300 unit/ml</i>	Non Preferred	PA
<i>insulin glargine solostar subcutaneous solution pen-injector 300 unit/ml</i>	Non Preferred	PA
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	Non Preferred	PA
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine-yfgn</i>)	Non Preferred	PA
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine-yfgn</i>)	Non Preferred	PA
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	Non Preferred	PA
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (<i>insulin glargine</i>)	Non Preferred	PA
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (<i>insulin degludec</i>)	Non Preferred	PA
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin degludec</i>)	Non Preferred	PA
INSULINS: RAPID-ACTING [OPEN CLASS]		
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin aspart injection solution 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin lispro injection solution 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml</i>	Preferred	90-day fill allowed after two 1-month fills
ADMELOG INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro</i>)	Preferred	90-day fill allowed after two 1-month fills
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
HUMALOG INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML (<i>insulin regular human</i>)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG INJECTION SOLUTION 100 UNIT/ML (<i>insulin aspart</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin aspart</i>)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML (<i>insulin aspart</i>)	Preferred	90-day fill allowed after two 1-month fills
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 & 60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT (<i>insulin regular human</i>)	Non Preferred	PA
APIDRA INJECTION SOLUTION 100 UNIT/ML (<i>insulin glulisine</i>)	Non Preferred	PA
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glulisine</i>)	Non Preferred	PA
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Non Preferred	PA
FIASP INJECTION SOLUTION 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Non Preferred	PA
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Non Preferred	PA
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin lispro</i>)	Non Preferred	PA
HUMALOG TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro</i>)	Non Preferred	PA
LYUMJEV INJECTION SOLUTION 100 UNIT/ML (<i>insulin lispro-aabc</i>)	Non Preferred	PA
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (<i>insulin lispro-aabc</i>)	Non Preferred	PA
LYUMJEV TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin lispro-aabc</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
INTRANASAL ANTIHISTAMINES [OPEN CLASS]		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	Preferred	
<i>azelastine hcl nasal solution 0.15 %</i>	Non Preferred	PA
<i>olopatadine hcl nasal solution 0.6 %</i>	Non Preferred	PA
PATANASE NASAL SOLUTION 0.6 % (<i>olopatadine hcl</i>)	Non Preferred	PA
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (<i>olopatadine-mometasone</i>)	Non Preferred	PA; AGE (Min 18 Years)
LEUKOTRIENE RECEPTOR ANTAGONISTS [OPEN CLASS]		
<i>montelukast sodium oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>montelukast sodium oral tablet chewable 4 mg</i>	Preferred	AGE (Max 5 Years); 90-day fill allowed after two 1-month fills
<i>montelukast sodium oral tablet chewable 5 mg</i>	Preferred	AGE (Max 14 Years); 90-day fill allowed after two 1-month fills
<i>montelukast sodium oral packet 4 mg</i>	Non Preferred	PA; AGE (Max 5 Years)
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	Non Preferred	PA
<i>zileuton er oral tablet extended release 12 hour 600 mg</i>	Non Preferred	PA
ACCOLATE ORAL TABLET 10 MG, 20 MG (<i>zafirlukast</i>)	Non Preferred	PA
SINGULAIR ORAL PACKET 4 MG (<i>montelukast sodium</i>)	Non Preferred	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET 10 MG (<i>montelukast sodium</i>)	Non Preferred	PA
SINGULAIR ORAL TABLET CHEWABLE 4 MG (<i>montelukast sodium</i>)	Non Preferred	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET CHEWABLE 5 MG (<i>montelukast sodium</i>)	Non Preferred	PA; AGE (Max 14 Years)
ZYFLO ORAL TABLET 600 MG (<i>zileuton</i>)	Non Preferred	PA
LIPOTROPICS: BILE ACID SEQUESTRANTS [OPEN CLASS]		
<i>cholestyramine light oral packet 4 gm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cholestyramine light oral powder 4 gm/dose</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cholestyramine oral packet 4 gm</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>cholestyramine oral powder 4 gm/dose</i>	Preferred	90-day fill allowed after two 1-month fills
<i>colestipol hcl oral tablet 1 gm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cholestyramine light (Prevalite Oral Packet 4 Gm)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cholestyramine light (Prevalite Oral Powder 4 Gm/Dose)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>colesevelam hcl oral packet 3.75 gm</i>	Non Preferred	PA
<i>colesevelam hcl oral tablet 625 mg</i>	Non Preferred	PA
<i>colestipol hcl oral granules 5 gm</i>	Non Preferred	PA
<i>colestipol hcl oral packet 5 gm</i>	Non Preferred	PA
COLESTID ORAL GRANULES 5 GM (<i>colestipol hcl</i>)	Non Preferred	PA
COLESTID ORAL PACKET 5 GM (<i>colestipol hcl</i>)	Non Preferred	PA
COLESTID ORAL TABLET 1 GM (<i>colestipol hcl</i>)	Non Preferred	PA
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (<i>cholestyramine light</i>)	Non Preferred	PA
QUESTRAN ORAL PACKET 4 GM (<i>cholestyramine</i>)	Non Preferred	PA
QUESTRAN ORAL POWDER 4 GM/DOSE (<i>cholestyramine</i>)	Non Preferred	PA
WELCHOL ORAL PACKET 3.75 GM (<i>colesevelam hcl</i>)	Non Preferred	PA
WELCHOL ORAL TABLET 625 MG (<i>colesevelam hcl</i>)	Non Preferred	PA
LIPOTROPICS: CHOLESTEROL ABSORPTION INHIBITORS (CAI) AND/OR ADENOSINE TRIPHOSPHATE CITRATE LYASE (ACL) INHIBITORS [OPEN CLASS]		
<i>ezetimibe oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	Non Preferred	PA; AGE (Min 18 Years)
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZETIA ORAL TABLET 10 MG (<i>ezetimibe</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LIPOTROPICS: FIBRIC ACID DERIVATIVES [OPEN CLASS]		
<i>fenofibrate oral tablet 145 mg, 48 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gemfibrozil oral tablet 600 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg, 90 mg</i>	Non Preferred	PA
<i>fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg</i>	Non Preferred	PA
<i>fenofibrate oral tablet 120 mg, 160 mg, 40 mg, 54 mg</i>	Non Preferred	PA
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	Non Preferred	PA
<i>fenofibric acid oral tablet 105 mg, 35 mg</i>	Non Preferred	PA
FENOGLIDE ORAL TABLET 120 MG, 40 MG (<i>fenofibrate</i>)	Non Preferred	PA
FIBRICOR ORAL TABLET 105 MG, 35 MG (<i>fenofibric acid</i>)	Non Preferred	PA
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (<i>fenofibrate</i>)	Non Preferred	PA
LOPID ORAL TABLET 600 MG (<i>gemfibrozil</i>)	Non Preferred	PA
TRICOR ORAL TABLET 145 MG, 48 MG (<i>fenofibrate</i>)	Non Preferred	PA
TRILIPIX ORAL CAPSULE DELAYED RELEASE 135 MG, 45 MG (<i>choline fenofibrate</i>)	Non Preferred	PA
LIPOTROPICS: JUXTAPID [OPEN CLASS]		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG (<i>lomitapide mesylate</i>)	Non Preferred	SP; PA
LIPOTROPICS: NIACIN DERIVATIVES [OPEN CLASS]		
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	Preferred	
LIPOTROPICS: OMEGA 3 FATTY ACID AGENTS [OPEN CLASS]		
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	Preferred	
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM (<i>icosapent ethyl</i>)	Preferred	PA; AGE (Min 18 Years)
<i>icosapent ethyl oral capsule 0.5 gm, 1 gm</i>	Non Preferred	PA; AGE (Min 18 Years)
LOVAZA ORAL CAPSULE 1 GM (<i>omega-3-acid ethyl esters</i>)	Non Preferred	PA
LIPOTROPICS: PCSK9 [OPEN CLASS]		
LEQVIO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML (<i>inclisiran sodium</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML (<i>alirocumab</i>)	Non Preferred	PA
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (<i>evolocumab</i>)	Non Preferred	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	Non Preferred	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	Non Preferred	PA
LIPOTROPICS: STATINS [OPEN CLASS]		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	Non Preferred	PA
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	Non Preferred	PA
<i>flolipid oral suspension 40 mg/5ml</i>	Non Preferred	PA
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	Non Preferred	PA
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	Non Preferred	PA
<i>pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg</i>	Non Preferred	PA
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HOUR 20 MG, 40 MG, 60 MG (<i>lovastatin</i>)	Non Preferred	PA
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (<i>atorvastatin calcium</i>)	Non Preferred	PA
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (<i>rosuvastatin calcium</i>)	Non Preferred	PA
LESCOL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 80 MG (<i>fluvastatin sodium</i>)	Non Preferred	PA
LIPITOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG (<i>atorvastatin calcium</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (<i>pitavastatin calcium</i>)	Non Preferred	PA
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG (<i>ezetimibe-simvastatin</i>)	Non Preferred	PA
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG (<i>simvastatin</i>)	Non Preferred	PA
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (<i>pitavastatin magnesium</i>)	Non Preferred	PA
MACROLIDES: ORAL [OPEN CLASS]		
<i>azithromycin oral packet 1 gm</i>	Preferred	
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	Preferred	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	Preferred	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	Preferred	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	Preferred	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml</i>	Preferred	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	Preferred	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	Non Preferred	PA
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	Non Preferred	PA
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	Non Preferred	PA
<i>erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml</i>	Non Preferred	PA
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	Non Preferred	PA
E.E.S. 400 ORAL TABLET 400 MG (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
<i>erythromycin base (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg)</i>	Non Preferred	PA
ERYTHROCIN STEARATE ORAL TABLET 250 MG (<i>erythromycin stearate</i>)	Non Preferred	PA
ZITHROMAX ORAL PACKET 1 GM (<i>azithromycin</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX ORAL TABLET 250 MG, 500 MG (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX Z-PAK ORAL TABLET 250 MG (<i>azithromycin</i>)	Non Preferred	PA
MOVEMENT DISORDERS [CLOSED CLASS]		
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	Preferred	SP; PA (Eligible for auto-PA approval); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (<i>deutetrabenazine</i>)	Preferred	SP; PA (Eligible for auto-PA approval); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (<i>deutetrabenazine</i>)	Preferred	SP; PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG (<i>deutetrabenazine</i>)	Preferred	SP; PA (Eligible for auto-PA approval); QL (42 EA per 365 days); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE 40 MG, 80 MG (<i>valbenazine tosylate</i>)	Preferred	SP; PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE 60 MG (<i>valbenazine tosylate</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (<i>valbenazine tosylate</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (<i>valbenazine tosylate</i>)	Preferred	SP; PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
XENAZINE ORAL TABLET 12.5 MG, 25 MG (<i>tetrabenazine</i>)	Preferred	SP; PA (Eligible for auto-PA approval); QL (4 EA per 1 day); AGE (Min 18 Years)
MULTIPLE SCLEROSIS [CLOSED CLASS]		
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	Preferred	SP; PA
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
<i> fingolimod hcl oral capsule 0.5 mg</i>	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 10 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (<i>glatiramer acetate</i>)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (<i>ofatumumab</i>)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i>	Non Preferred	SP; PA; AGE (Min 18 Years)
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HOUR 10 MG (<i>dalfampridine</i>)	Non Preferred	SP; PA
AUBAGIO ORAL TABLET 14 MG, 7 MG (<i>teriflunomide</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (<i>monomethyl fumarate</i>)	Non Preferred	SP; PA
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML (<i>ublituximab-xiyy</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (<i>glatiramer acetate</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
GILENYA ORAL CAPSULE 0.25 MG, 0.5 MG (<i>fingolimod hcl</i>)	Non Preferred	SP; PA; AGE (Min 10 Years)
<i>glatiramer acetate</i> (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/ML, 40 Mg/ML)	Non Preferred	SP; PA; AGE (Min 18 Years)
LEMTRADA INTRAVENOUS SOLUTION 12 MG/1.2ML (<i>alemtuzumab</i>)	Non Preferred	SP; PA
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA

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Drug Name	Formulary Status	Requirements/Limits
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Non Preferred	SP; PA
MAYZENT ORAL TABLET 0.25 MG, 2 MG (<i>siponimod fumarate</i>)	Non Preferred	SP; PA
MAYZENT ORAL TABLET 1 MG (<i>siponimod fumarate</i>)	Non Preferred	PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	Non Preferred	SP; PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	Non Preferred	PA
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML (<i>ocrelizumab</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
OCREVUS ZUNOVO SUBCUTANEOUS SOLUTION 920-23000 MG-UT/23ML (<i>ocrelizumab-hyaluronidase-ocsq</i>)	Non Preferred	PA; AGE (Min 18 Years)
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Non Preferred	SP; PA
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Non Preferred	SP; PA
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Non Preferred	SP; PA
PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Non Preferred	SP; PA
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Non Preferred	SP; PA
PONVORY ORAL TABLET 20 MG (<i>ponesimod</i>)	Non Preferred	SP; PA
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG (<i>ponesimod</i>)	Non Preferred	SP; PA
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML (<i>interferon beta-1a</i>)	Non Preferred	SP; PA
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (<i>interferon beta-1a</i>)	Non Preferred	SP; PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (<i>interferon beta-1a</i>)	Non Preferred	SP; PA
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (<i>interferon beta-1a</i>)	Non Preferred	SP; PA
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG (<i>fingolimod lauryl sulfate</i>)	Non Preferred	SP; PA; AGE (Min 10 Years and Max 17 Years)
TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG, 240 MG (<i>dimethyl fumarate</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG (<i>dimethyl fumarate</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML (<i>natalizumab</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG (<i>diroximel fumarate</i>)	Non Preferred	SP; PA
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (<i>ozanimod hcl</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZEPOSIA ORAL CAPSULE 0.92 MG (<i>ozanimod hcl</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) (<i>ozanimod hcl</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
NASAL STEROIDS [OPEN CLASS]		
<i>allergy relief nasal suspension 50 mcg/act</i>	Preferred	
<i>fluticasone propionate suspension 50 mcg/act nasal (otc)</i>	Preferred	
<i>fluticasone propionate suspension 50 mcg/act nasal (rx)</i>	Preferred	
<i>ft 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	Preferred	
<i>ft allergy relief 24 hr nasal suspension 50 mcg/act</i>	Preferred	
<i>gnp 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	Preferred	
<i>gnp fluticasone propionate nasal suspension 50 mcg/act</i>	Preferred	
<i>goodsense 24-hr allergy nasal nasal suspension 50 mcg/act</i>	Preferred	
<i>goodsense nasal allergy spray nasal aerosol 55 mcg/act</i>	Preferred	
<i>hm 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	Preferred	
<i>hm allergy relief nasal suspension 50 mcg/act</i>	Preferred	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	Preferred	
<i>nasal allergy 24 hour nasal aerosol 55 mcg/act</i>	Preferred	
<i>sm allergy relief nasal suspension 50 mcg/act</i>	Preferred	
<i>triamcinolone acetonide nasal aerosol 55 mcg/act</i>	Preferred	
DYMISTA NASAL SUSPENSION 137-50 MCG/ACT (<i>azelastine-fluticasone</i>)	Preferred	AGE (Min 6 Years)
<i>allergy nasal spray nasal suspension 50 mcg/act</i>	Non Preferred	PA
<i>azelastine-fluticasone nasal suspension 137-50 mcg/act</i>	Non Preferred	PA; AGE (Min 6 Years)
<i>budesonide nasal suspension 32 mcg/act</i>	Non Preferred	PA
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	Non Preferred	PA
<i>gnp budesonide nasal spray nasal suspension 32 mcg/act</i>	Non Preferred	PA
<i>mometasone furoate suspension 50 mcg/act nasal (otc)</i>	Non Preferred	PA
<i>mometasone furoate suspension 50 mcg/act nasal (rx)</i>	Non Preferred	PA
BECONASE AQ NASAL SUSPENSION 42 MCG/SPRAY (<i>beclomethasone diprop monohyd</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
NASONEX 24HR NASAL SUSPENSION 50 MCG/ACT (mometasone furoate)	Non Preferred	PA
OMNARIS NASAL SUSPENSION 50 MCG/ACT (ciclesonide)	Non Preferred	PA
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (beclomethasone diprop (nasal))	Non Preferred	PA
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (beclomethasone diprop (nasal))	Non Preferred	PA
XHANCE NASAL EXHALER SUSPENSION 93 MCG/ACT (fluticasone propionate)	Non Preferred	PA
ZETONNA NASAL AEROSOL SOLUTION 37 MCG/ACT (ciclesonide)	Non Preferred	PA
NEUROPATHIC PAIN [OPEN CLASS]		
arthritis pain relieving external cream 0.075 %	Preferred	
capsaicin external cream 0.025 %, 0.075 %, 0.1 %	Preferred	
capsaicin pain relief external cream 0.1 %	Preferred	
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	Preferred	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	Preferred	
gabapentin oral solution 250 mg/5ml, 300 mg/6ml	Preferred	
gabapentin oral tablet 600 mg, 800 mg	Preferred	
gnp capsaicin external liquid 0.15 %	Preferred	
lidocaine external patch 5 %	Preferred	QL (90 EA per 1 Fill)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	Preferred	
lidocaine (Lidocan Patch 5 % External)	Preferred	QL (90 EA per 1 Fill)
lidocaine (Tridacaine Ii External Patch 5 %)	Preferred	QL (90 EA per 1 Fill)
lidocaine (Tridacaine Iii External Patch 5 %)	Preferred	QL (90 EA per 1 Fill)
duloxetine hcl oral capsule delayed release particles 40 mg	Non Preferred	PA
gabapentin (once-daily) oral tablet 300 mg, 600 mg	Non Preferred	PA
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	Non Preferred	PA
pregabalin oral solution 20 mg/ml	Non Preferred	PA
CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 20 MG, 30 MG, 60 MG (duloxetine hcl)	Non Preferred	PA
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG (duloxetine hcl)	Non Preferred	PA
GRALISE ORAL TABLET 300 MG, 450 MG, 600 MG, 750 MG, 900 MG (gabapentin (once-daily))	Non Preferred	PA
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG (gabapentin enacarbil)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>lidocaine</i> (Lidocan Patch 5 % External)	Non Preferred	PA; QL (90 EA per 1 Fill)
LIDODERM EXTERNAL PATCH 5 % (<i>lidocaine</i>)	Non Preferred	PA; QL (90 EA per 1 Fill)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 330 MG, 82.5 MG (<i>pregabalin</i>)	Non Preferred	PA
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (<i>pregabalin</i>)	Non Preferred	PA
LYRICA ORAL SOLUTION 20 MG/ML (<i>pregabalin</i>)	Non Preferred	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (<i>gabapentin</i>)	Non Preferred	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (<i>gabapentin</i>)	Non Preferred	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (<i>gabapentin</i>)	Non Preferred	PA
QUTENZA (2 PATCH) EXTERNAL KIT 8 % (<i>capsaicin-cleansing gel</i>)	Non Preferred	SP; PA
QUTENZA (4 PATCH) EXTERNAL KIT 8 % (<i>capsaicin-cleansing gel</i>)	Non Preferred	SP; PA
QUTENZA EXTERNAL KIT 8 % (<i>capsaicin-cleansing gel</i>)	Non Preferred	SP; PA
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	Non Preferred	PA
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	Non Preferred	PA
XYLIDERM EXTERNAL KIT 5 % (<i>lidocaine-adhesive sheets</i>)	Non Preferred	PA
ZTLIDO EXTERNAL PATCH 1.8 % (<i>lidocaine</i>)	Non Preferred	PA
NON-ERGOT DOPAMINE RECEPTOR AGONISTS [OPEN CLASS]		
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ropinirole hcl er oral tablet extended release 24 hour 2 mg, 8 mg</i>	Preferred	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</i>	Non Preferred	PA
<i>ropinirole hcl er oral tablet extended release 24 hour 12 mg, 4 mg, 6 mg</i>	Non Preferred	PA
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 0.375 MG, 0.75 MG, 2.25 MG, 3 MG, 3.75 MG, 4.5 MG (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (rotigotine)	Non Preferred	PA
NSAIDS [OPEN CLASS]		
<i>all day pain relief oral tablet 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>all day relief oral tablet 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>arthritis pain reliever external gel 1 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>celecoxib oral capsule 100 mg, 200 mg</i>	Preferred	
<i>childrens ibuprofen oral suspension 100 mg/5ml</i>	Preferred	
<i>diclofenac epolamine external patch 1.3 %</i>	Preferred	QL (30 EA per 1 Fill)
<i>diclofenac sodium gel 1 % external (otc)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diclofenac sodium gel 1 % external (rx)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>diflunisal oral tablet 500 mg</i>	Preferred	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>etodolac oral capsule 200 mg, 300 mg</i>	Preferred	
<i>etodolac oral tablet 400 mg, 500 mg</i>	Preferred	
<i>flurbiprofen oral tablet 100 mg</i>	Preferred	
<i>ft all day pain relief oral tablet 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft arthritis pain external gel 1 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	
<i>ft ibuprofen ib childrens oral tablet chewable 100 mg</i>	Preferred	
<i>ft ibuprofen minis oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft ibuprofen oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft ibuprofen oral tablet 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft naproxen sodium oral capsule 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft pain relief oral tablet 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp arthritis pain external gel 1 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp childrens ibuprofen oral suspension 100 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp diclofenac sodium external gel 1 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp ibuprofen childrens oral tablet chewable 100 mg</i>	Preferred	
<i>gnp ibuprofen infants oral suspension 50 mg/1.25ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp ibuprofen oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp ibuprofen oral tablet 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp naproxen sodium oral capsule 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp naproxen sodium oral tablet 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense arthritis pain external gel 1 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	
<i>goodsense ibuprofen childrens oral tablet chewable 100 mg</i>	Preferred	
<i>goodsense ibuprofen infants oral suspension 50 mg/1.25ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense ibuprofen oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense ibuprofen oral tablet 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense naproxen sodium oral tablet 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hm ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	
<i>ibuprofen childrens oral suspension 100 mg/5ml</i>	Preferred	
<i>ibuprofen infants oral suspension 50 mg/1.25ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ibuprofen junior strength oral tablet chewable 100 mg</i>	Preferred	
<i>ibuprofen oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ibuprofen oral suspension 100 mg/5ml</i>	Preferred	
<i>ibuprofen oral tablet 200 mg, 400 mg, 600 mg, 800 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>indomethacin oral capsule 25 mg, 50 mg</i>	Preferred	
<i>infants ibuprofen oral suspension 50 mg/1.25ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ketorolac tromethamine oral tablet 10 mg</i>	Preferred	Max 5 days of therapy every 90 days; QL (4 EA per 1 day)
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>naproxen dr oral tablet delayed release 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>naproxen sodium oral capsule 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>naproxen sodium oral tablet 220 mg, 275 mg, 550 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm arthritis pain external gel 1 %</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm childrens ibuprofen oral suspension 100 mg/5ml</i>	Preferred	
<i>sm ibuprofen ib childrens oral tablet chewable 100 mg</i>	Preferred	
<i>sm ibuprofen oral capsule 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm ibuprofen oral tablet 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm infants ibuprofen oral suspension 50 mg/1.25ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm naproxen sodium oral tablet 220 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sulindac oral tablet 150 mg, 200 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ibuprofen (Ibu Oral Tablet 400 Mg, 600 Mg, 800 Mg)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>celecoxib oral capsule 400 mg, 50 mg</i>	Non Preferred	PA
<i>diclofenac potassium oral capsule 25 mg</i>	Non Preferred	PA
<i>diclofenac potassium oral tablet 25 mg, 50 mg</i>	Non Preferred	PA
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	Non Preferred	PA
<i>diclofenac sodium external solution 1.5 %, 2 %</i>	Non Preferred	PA
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	Non Preferred	PA
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	Non Preferred	PA
<i>fenoprofen calcium oral capsule 400 mg</i>	Non Preferred	PA
<i>fenoprofen calcium oral tablet 600 mg</i>	Non Preferred	PA
<i>ibuprofen-famotidine oral tablet 800-26.6 mg</i>	Non Preferred	PA
<i>indomethacin er oral capsule extended release 75 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>indomethacin oral suspension 25 mg/5ml</i>	Non Preferred	PA
<i>indomethacin rectal suppository 50 mg</i>	Non Preferred	PA
<i>ketoprofen er oral capsule extended release 24 hour 200 mg</i>	Non Preferred	PA
<i>ketoprofen oral capsule 50 mg, 75 mg</i>	Non Preferred	PA
<i>ketorolac tromethamine nasal solution 15.75 mg/spray</i>	Non Preferred	PA
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	Non Preferred	PA
<i>mefenamic acid oral capsule 250 mg</i>	Non Preferred	PA
<i>meloxicam oral capsule 10 mg, 5 mg</i>	Non Preferred	PA
<i>nabumetone oral tablet 500 mg, 750 mg</i>	Non Preferred	PA
<i>naproxen oral suspension 125 mg/5ml</i>	Non Preferred	PA
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg</i>	Non Preferred	PA
<i>naproxen-esomeprazole mg oral tablet delayed release 375-20 mg, 500-20 mg</i>	Non Preferred	PA
<i>oxaprozin oral tablet 600 mg</i>	Non Preferred	PA
<i>piroxicam oral capsule 10 mg, 20 mg</i>	Non Preferred	PA
<i>tolmetin sodium oral capsule 400 mg</i>	Non Preferred	PA
<i>tolmetin sodium oral tablet 600 mg</i>	Non Preferred	PA
ARTHROTEC ORAL TABLET DELAYED RELEASE 50-0.2 MG, 75-0.2 MG (<i>diclofenac-misoprostol</i>)	Non Preferred	PA
CELEBREX ORAL CAPSULE 100 MG, 200 MG, 400 MG, 50 MG (<i>celecoxib</i>)	Non Preferred	PA
DAYPRO ORAL TABLET 600 MG (<i>oxaprozin</i>)	Non Preferred	PA
DUEXIS ORAL TABLET 800-26.6 MG (<i>ibuprofen-famotidine</i>)	Non Preferred	PA
FELDENE ORAL CAPSULE 10 MG, 20 MG (<i>piroxicam</i>)	Non Preferred	PA
FLECTOR EXTERNAL PATCH 1.3 % (<i>diclofenac epolamine</i>)	Non Preferred	PA; QL (30 EA per 1 Fill)
KIPROFEN ORAL CAPSULE 25 MG (<i>ketoprofen</i>)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
LICART EXTERNAL PATCH 24 HOUR 1.3 % (<i>diclofenac epolamine</i>)	Non Preferred	PA; QL (30 EA per 1 Fill)
<i>diclofenac potassium</i> (Lofena Oral Tablet 25 Mg)	Non Preferred	PA
NALFON ORAL CAPSULE 400 MG (<i>fenoprofen calcium</i>)	Non Preferred	PA
NALFON ORAL TABLET 600 MG (<i>fenoprofen calcium</i>)	Non Preferred	PA
NAPRELAN ORAL TABLET EXTENDED RELEASE 24 HOUR 375 MG, 500 MG, 750 MG (<i>naproxen sodium</i>)	Non Preferred	PA
NAPROSYN ORAL SUSPENSION 125 MG/5ML (<i>naproxen</i>)	Non Preferred	PA
PENNSAID EXTERNAL SOLUTION 2 % (<i>diclofenac sodium</i>)	Non Preferred	PA
RELAFEN DS ORAL TABLET 1000 MG (<i>nabumetone</i>)	Non Preferred	PA
TOLECTIN 600 ORAL TABLET 600 MG (<i>tolmetin sodium</i>)	Non Preferred	PA
VIMOVO ORAL TABLET DELAYED RELEASE 375-20 MG, 500-20 MG (<i>naproxen-esomeprazole</i>)	Non Preferred	PA
OPHTHALMIC ANTIBIOTICS [OPEN CLASS]		
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	Preferred	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	Preferred	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	Preferred	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	Preferred	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	Preferred	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	Preferred	
<i>ofloxacin ophthalmic solution 0.3 %</i>	Preferred	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	Preferred	
<i>tobramycin ophthalmic solution 0.3 %</i>	Preferred	
<i>bacitracin-polymyxin b</i> (Polycin Ophthalmic Ointment 500-10000 Unit/Gm)	Preferred	
<i>gatifloxacin ophthalmic solution 0.5 %</i>	Non Preferred	PA
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	Non Preferred	PA
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000</i>	Non Preferred	PA
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	Non Preferred	PA
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	Non Preferred	PA
AZASITE OPHTHALMIC SOLUTION 1 % (<i>azithromycin</i>)	Non Preferred	PA
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (<i>besifloxacin hcl</i>)	Non Preferred	PA
CILOXAN OPHTHALMIC OINTMENT 0.3 % (<i>ciprofloxacin hcl</i>)	Non Preferred	PA
NATACYN OPHTHALMIC SUSPENSION 5 % (<i>natamycin</i>)	Non Preferred	PA
<i>neomycin-bacitracin zn-polymyx</i> (Neo-Polycin Ophthalmic Ointment 3.5-400-10000)	Non Preferred	PA
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (<i>ofloxacin</i>)	Non Preferred	PA
TOBREX OPHTHALMIC OINTMENT 0.3 % (<i>tobramycin</i>)	Non Preferred	PA
VIGAMOX OPHTHALMIC SOLUTION 0.5 % (<i>moxifloxacin hcl</i>)	Non Preferred	PA
OPHTHALMIC ANTIBIOTICS: STEROID COMBINATIONS [OPEN CLASS]		
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	Preferred	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	Preferred	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	Preferred	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	Preferred	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	Preferred	
TOBRADEX OPHTHALMIC SUSPENSION 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	Preferred	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	Non Preferred	PA
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	Non Preferred	PA
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (<i>neomycin-polymyxin-dexameth</i>)	Non Preferred	PA
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (<i>neomycin-polymyxin-dexameth</i>)	Non Preferred	PA
<i>bacitracin-polymyx-neo-hc</i> (Neo-Polycin Hc Ophthalmic Ointment 1 %)	Non Preferred	PA
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (<i>tobramycin-dexamethasone</i>)	Non Preferred	PA
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (<i>loteprednol-tobramycin</i>)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
OPHTHALMICS: ALLERGIC CONJUNCTIVITIS [OPEN CLASS]		
<i>azelastine hcl ophthalmic solution 0.05 %</i>	Preferred	
<i>cromolyn sodium ophthalmic solution 4 %</i>	Preferred	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	Preferred	
<i>eye allergy itch relief ophthalmic solution 0.2 %</i>	Preferred	
<i>eye allergy itch/redness rel ophthalmic solution 0.1 %</i>	Preferred	
<i>eye itch relief ophthalmic solution 0.035 %</i>	Preferred	
<i>ft eye allergy itch & redness ophthalmic solution 0.1 %</i>	Preferred	
<i>ft eye allergy itch relief ophthalmic solution 0.2 %</i>	Preferred	
<i>gnp olopatadine hcl ophthalmic solution 0.1 %, 0.2 %</i>	Preferred	
<i>hm eye allergy itch relief ophthalmic solution 0.2 %</i>	Preferred	
<i>hm eye allergy itch/red relief ophthalmic solution 0.1 %</i>	Preferred	
<i>ketotifen fumarate ophthalmic solution 0.035 %</i>	Preferred	
<i>olopatadine hcl solution 0.1 % ophthalmic (otc)</i>	Preferred	
<i>olopatadine hcl solution 0.1 % ophthalmic (rx)</i>	Preferred	
<i>olopatadine hcl solution 0.2 % ophthalmic (otc)</i>	Preferred	
<i>olopatadine hcl solution 0.2 % ophthalmic (rx)</i>	Preferred	
<i>sm olopatadine hcl ophthalmic solution 0.2 %</i>	Preferred	
ALAWAY CHILDRENS ALLERGY OPHTHALMIC SOLUTION 0.035 % (<i>ketotifen fumarate</i>)	Preferred	
ALAWAY OPHTHALMIC SOLUTION 0.035 % (<i>ketotifen fumarate</i>)	Preferred	
ZADITOR OPHTHALMIC SOLUTION 0.035 % (<i>ketotifen fumarate</i>)	Preferred	
<i>bepotastine besilate ophthalmic solution 1.5 %</i>	Non Preferred	PA
ALOCRIAL OPHTHALMIC SOLUTION 2 % (<i>nedocromil sodium</i>)	Non Preferred	PA
ALOMIDE OPHTHALMIC SOLUTION 0.1 % (<i>lodoxamide tromethamine</i>)	Non Preferred	PA
BEPREVE OPHTHALMIC SOLUTION 1.5 % (<i>bepotastine besilate</i>)	Non Preferred	PA
LASTACRAFT OPHTHALMIC SOLUTION 0.25 % (<i>alcaftadine</i>)	Non Preferred	PA
PATADAY OPHTHALMIC SOLUTION 0.1 %, 0.2 %, 0.7 % (<i>olopatadine hcl</i>)	Non Preferred	PA
ZERVIAE OPHTHALMIC SOLUTION 0.24 % (<i>cetirizine hcl</i>)	Non Preferred	PA
OPHTHALMICS: ANTI-INFLAMMATORY [OPEN CLASS]		
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	Preferred	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	Preferred	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	Preferred	
<i>loteprednol etabonate ophthalmic gel 0.5 %</i>	Preferred	
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	Preferred	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	Preferred	
DUREZOL OPHTHALMIC EMULSION 0.05 % (<i>difluprednate</i>)	Preferred	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</i>	Non Preferred	PA
<i>bromfenac sodium ophthalmic solution 0.07 %, 0.075 %</i>	Non Preferred	PA
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	Non Preferred	PA
<i>difluprednate ophthalmic emulsion 0.05 %</i>	Non Preferred	PA
<i>loteprednol etabonate ophthalmic suspension 0.2 %</i>	Non Preferred	PA
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	Non Preferred	PA
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (<i>ketorolac tromethamine</i>)	Non Preferred	PA
ACULAR OPHTHALMIC SOLUTION 0.5 % (<i>ketorolac tromethamine</i>)	Non Preferred	PA
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (<i>ketorolac tromethamine</i>)	Non Preferred	PA
ALREX OPHTHALMIC SUSPENSION 0.2 % (<i>loteprednol etabonate</i>)	Non Preferred	PA
BROMSITE OPHTHALMIC SOLUTION 0.075 % (<i>bromfenac sodium</i>)	Non Preferred	PA
FLAREX OPHTHALMIC SUSPENSION 0.1 % (<i>fluorometholone acetate</i>)	Non Preferred	PA
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (<i>fluorometholone</i>)	Non Preferred	PA
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (<i>fluorometholone</i>)	Non Preferred	PA
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (<i>nepafenac</i>)	Non Preferred	PA
INVELTYS OPHTHALMIC SUSPENSION 1 % (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX OPHTHALMIC GEL 0.5 % (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX OPHTHALMIC SUSPENSION 0.5 % (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX SM OPHTHALMIC GEL 0.38 % (<i>loteprednol etabonate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (<i>dexamethasone</i>)	Non Preferred	PA
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (<i>nepafenac</i>)	Non Preferred	PA
PRED FORTE OPHTHALMIC SUSPENSION 1 % (<i>prednisolone acetate</i>)	Non Preferred	PA
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (<i>prednisolone acetate</i>)	Non Preferred	PA
PROLENSA OPHTHALMIC SOLUTION 0.07 % (<i>bromfenac sodium</i>)	Non Preferred	PA
OPHTHALMICS: GLAUCOMA AGENTS [OPEN CLASS]		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	Preferred	
<i>brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %</i>	Preferred	
<i>brinzolamide ophthalmic suspension 1 %</i>	Preferred	
<i>carteolol hcl ophthalmic solution 1 %</i>	Preferred	
<i>dorzolamide hcl ophthalmic solution 2 %</i>	Preferred	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	Preferred	
<i>latanoprost ophthalmic solution 0.005 %</i>	Preferred	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	Preferred	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	Preferred	
<i>timolol maleate (once-daily) solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	Preferred	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	Preferred	
<i>timolol maleate pf ophthalmic solution 0.5 %</i>	Preferred	QL (2 EA per 1 day)
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	Preferred	
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %, 0.15 % (<i>brimonidine tartrate</i>)	Preferred	
AZOPT OPHTHALMIC SUSPENSION 1 % (<i>brinzolamide</i>)	Preferred	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (<i>brimonidine tartrate-timolol</i>)	Preferred	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (<i>netarsudil dimesylate</i>)	Preferred	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	Preferred	
<i>timolol maleate (Timolol Maleate OcuDose Ophthalmic Solution 0.5 %)</i>	Preferred	QL (2 EA per 1 day)
TRAVATAN Z OPHTHALMIC SOLUTION 0.004 % (<i>travoprost</i>)	Preferred	
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	Non Preferred	PA
<i>bimatoprost ophthalmic solution 0.03 %</i>	Non Preferred	PA
<i>brimonidine tartrate ophthalmic solution 0.1 %</i>	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	Non Preferred	PA
<i>dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>timolol maleate (once-daily) solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>timolol maleate pf ophthalmic solution 0.25 %</i>	Non Preferred	PA; QL (2 EA per 1 day)
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol hemihydrate</i>)	Non Preferred	PA
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	Non Preferred	PA
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (<i>dorzolamide hcl-timolol mal</i>)	Non Preferred	PA
COSOPT PF OPHTHALMIC SOLUTION 2-0.5 % (<i>dorzolamide hcl-timolol mal</i>)	Non Preferred	PA; QL (2 EA per 1 day)
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	Non Preferred	PA
ISTALOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol maleate</i>)	Non Preferred	PA
IYUZEH OPHTHALMIC SOLUTION 0.005 % (<i>latanoprost</i>)	Non Preferred	PA
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (<i>bimatoprost</i>)	Non Preferred	PA
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (<i>echothiophate iodide</i>)	Non Preferred	PA
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (<i>brinzolamide-brimonidine</i>)	Non Preferred	PA
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	Non Preferred	PA; QL (2 EA per 1 day)
TIMOPTIC OPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	Non Preferred	PA
TIMOPTIC-XE OPHTHALMIC GEL FORMING SOLUTION 0.25 %, 0.5 % (<i>timolol maleate</i>)	Non Preferred	PA
VUITY OPHTHALMIC SOLUTION 1.25 % (<i>pilocarpine hcl</i>)	Non Preferred	PA
VYZULTA OPHTHALMIC SOLUTION 0.024 % (<i>latanoprostene bunod</i>)	Non Preferred	PA
XALATAN OPHTHALMIC SOLUTION 0.005 % (<i>latanoprost</i>)	Non Preferred	PA
XELPROS OPHTHALMIC EMULSION 0.005 % (<i>latanoprost</i>)	Non Preferred	PA
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (<i>tafluprost</i>)	Non Preferred	PA; QL (1 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
OPHTHALMICS: IMMUNOMODULATORS [CLOSED CLASS]		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	Preferred	QL (5.5 ML per 30 days)
RESTASIS OPHTHALMIC EMULSION 0.05 % (<i>cyclosporine</i>)	Preferred	QL (60 EA per 30 days)
XIIDRA OPHTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	Preferred	QL (60 EA per 30 days)
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	Non Preferred	PA; QL (60 EA per 30 days)
CEQUA OPHTHALMIC SOLUTION 0.09 % (<i>cyclosporine</i>)	Non Preferred	PA
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (<i>loteprednol etabonate</i>)	Non Preferred	PA
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (<i>perfluorohexyloctane</i>)	Non Preferred	PA; QL (12 ML per 30 days); AGE (Min 18 Years)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	Non Preferred	PA
VERKAZIA OPHTHALMIC EMULSION 0.1 % (<i>cyclosporine</i>)	Non Preferred	PA
VEVYE OPHTHALMIC SOLUTION 0.1 % (<i>cyclosporine</i>)	Non Preferred	PA; QL (6 ML per 30 days)
OPIOID DEPENDENCY [CLOSED CLASS]		
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 1 day); AGE (Min 16 Years)
<i>lifems naloxone injection prefilled syringe kit 2 mg/2ml</i>	Preferred	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	Preferred	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	Preferred	
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	Preferred	
<i>naloxone hcl liquid 4 mg/0.1ml nasal (otc)</i>	Preferred	
<i>naloxone hcl liquid 4 mg/0.1ml nasal (rx)</i>	Preferred	
<i>naltrexone hcl oral tablet 50 mg</i>	Preferred	
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML, 24 MG/0.48ML, 32 MG/0.64ML, 8 MG/0.16ML (<i>buprenorphine</i>)	Preferred	AGE (Min 18 Years)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML, 64 MG/0.18ML, 96 MG/0.27ML (<i>buprenorphine</i>)	Preferred	AGE (Min 18 Years)
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (OTC) (<i>naloxone hcl</i>)	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (RX) (<i>naloxone hcl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (<i>nalmefene hcl</i>)	Preferred	QL (6 EA per 90 days); AGE (Min 12 Years); 90-day fill allowed after two 1-month fills
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	Preferred	
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (<i>buprenorphine</i>)	Preferred	SP
SUBOXONE SUBLINGUAL FILM 12-3 MG (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 1 day); AGE (Min 16 Years)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 8-2 MG (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 1 day); AGE (Min 16 Years)
SUBOXONE SUBLINGUAL FILM 4-1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 16 Years)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	Preferred	QL (1 EA per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (<i>naloxone hcl</i>)	Preferred	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 8-2 mg</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years)
<i>lofexidine hcl oral tablet 0.18 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
LUCEMYRA ORAL TABLET 0.18 MG (<i>lofexidine hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
OPIOIDS: LONG ACTING (LAO) [OPEN CLASS]		
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 5 mcg/hr, 7.5 mcg/hr</i>	Preferred	PA; QL (0.29 EA per 1 day)
<i>buprenorphine transdermal patch weekly 15 mcg/hr, 20 mcg/hr</i>	Preferred	PA; QL (0.15 EA per 1 day)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	Preferred	PA; QL (0.334 EA per 1 day)
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er oral tablet extended release 15 mg</i>	Preferred	PA; QL (4 EA per 1 day)
<i>morphine sulfate er oral tablet extended release 30 mg</i>	Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er oral tablet extended release 60 mg</i>	Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HR, 5 MCG/HR, 7.5 MCG/HR (<i>buprenorphine</i>)	Preferred	PA; QL (0.29 EA per 1 day)
BUTRANS TRANSDERMAL PATCH WEEKLY 15 MCG/HR, 20 MCG/HR (<i>buprenorphine</i>)	Preferred	PA; QL (0.15 EA per 1 day)
<i>fentanyl transdermal patch 72 hour 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 15 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 20 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 30 mg, 40 mg, 50 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg, 40 mg, 60 mg, 80 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 30 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydromorphone hcl er oral tablet extended release 24 hour 12 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 32 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydromorphone hcl er oral tablet extended release 24 hour 8 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>methadone hcl oral concentrate 10 mg/ml</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Max 1 Years)
<i>methadone hcl oral solution 10 mg/5ml</i>	Non Preferred	PA; QL (15 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl oral solution 5 mg/5ml</i>	Non Preferred	PA; QL (40 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl oral tablet 10 mg, 5 mg</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Max 1 Years)
<i>methadone hcl oral tablet soluble 40 mg</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Max 1 Years)
<i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 90 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er beads oral capsule extended release 24 hour 60 mg, 75 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour 10 mg</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour 100 mg, 80 mg</i>	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>morphine sulfate er oral capsule extended release 24 hour 20 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour 30 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 20 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 40 mg, 80 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 7.5 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour 15 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour 5 mg</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>tramadol hcl (er biphasic) oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 12 Years)
<i>tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 12 Years)
BELBUCA BUCCAL FILM 150 MCG (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
BELBUCA BUCCAL FILM 300 MCG, 600 MCG (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
BELBUCA BUCCAL FILM 450 MCG, 750 MCG, 900 MCG (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
BELBUCA BUCCAL FILM 75 MCG (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (6 EA per 1 day)
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (<i>tramadol hcl</i>)	Non Preferred	PA; AGE (Min 12 Years)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG, 120 MG, 40 MG, 60 MG, 80 MG (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 20 MG (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (3 EA per 1 day)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 30 MG (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (2 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
<i>methadone hcl</i> (Methadone Hcl Intensol Oral Concentrate 10 Mg/ML)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
METHADOSE ORAL CONCENTRATE 10 MG/ML (<i>methadone hcl</i>)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl</i> (Methadose Oral Tablet Soluble 40 Mg)	Non Preferred	PA; QL (3 EA per 1 day); AGE (Max 1 Years)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (<i>methadone hcl</i>)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG (<i>morphine sulfate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG (<i>morphine sulfate</i>)	Non Preferred	PA; QL (4 EA per 1 day)
MS CONTIN ORAL TABLET EXTENDED RELEASE 30 MG (<i>morphine sulfate</i>)	Non Preferred	PA; QL (3 EA per 1 day)
MS CONTIN ORAL TABLET EXTENDED RELEASE 60 MG (<i>morphine sulfate</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 50 MG (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (6 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 15 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (5 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 20 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 30 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 40 MG, 60 MG, 80 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG (<i>oxycodone</i>)	Non Preferred	PA; QL (5 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 18 MG (<i>oxycodone</i>)	Non Preferred	PA; QL (4 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 27 MG (<i>oxycodone</i>)	Non Preferred	PA; QL (3 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (<i>oxycodone</i>)	Non Preferred	PA; QL (2 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 9 MG (<i>oxycodone</i>)	Non Preferred	PA; QL (6 EA per 1 day)
OPIOIDS: SHORT ACTING [OPEN CLASS]		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	Preferred	QL (150 ML per 1 day); AGE (Min 12 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	Preferred	QL (10 EA per 1 day); AGE (Min 12 Years)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15ml</i>	Preferred	QL (135 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	Preferred	QL (180 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg</i>	Preferred	QL (9 EA per 1 day)
<i>hydrocodone-acetaminophen oral tablet 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	Preferred	QL (5 EA per 1 day)
<i>hydromorphone hcl oral tablet 2 mg</i>	Preferred	QL (11.2 EA per 1 day)
<i>hydromorphone hcl oral tablet 4 mg</i>	Preferred	QL (5.6 EA per 1 day)
<i>hydromorphone hcl oral tablet 8 mg</i>	Preferred	QL (2.8 EA per 1 day)
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate oral solution 10 mg/5ml</i>	Preferred	QL (45 ML per 1 day)
<i>morphine sulfate oral solution 20 mg/5ml</i>	Preferred	QL (22.5 ML per 1 day)
<i>morphine sulfate oral tablet 15 mg</i>	Preferred	QL (6 EA per 1 day)
<i>morphine sulfate oral tablet 30 mg</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl oral capsule 5 mg</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone hcl oral solution 5 mg/5ml</i>	Preferred	QL (60 ML per 1 day)
<i>oxycodone hcl oral tablet 10 mg</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone hcl oral tablet 15 mg</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl oral tablet 20 mg</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl oral tablet 30 mg</i>	Preferred	QL (2 EA per 1 day)
<i>oxycodone hcl oral tablet 5 mg</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	Preferred	QL (60 ML per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 7.5-325 mg</i>	Preferred	QL (8 EA per 1 day)
<i>tramadol hcl oral tablet 50 mg</i>	Preferred	QL (8 EA per 1 day); AGE (Min 12 Years)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	Preferred	QL (8 EA per 1 day); AGE (Min 12 Years)
<i>apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>codeine sulfate oral tablet 15 mg</i>	Non Preferred	PA; QL (24 EA per 1 day); AGE (Min 12 Years)
<i>codeine sulfate oral tablet 30 mg</i>	Non Preferred	PA; QL (12 EA per 1 day); AGE (Min 12 Years)
<i>codeine sulfate oral tablet 60 mg</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 12 Years)
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	Non Preferred	PA
<i>fentanyl citrate buccal tablet 200 mcg</i>	Non Preferred	PA; QL (3.6 EA per 1 day)
<i>fentanyl citrate buccal tablet 400 mcg</i>	Non Preferred	PA; QL (1.8 EA per 1 day)
<i>fentanyl citrate buccal tablet 600 mcg</i>	Non Preferred	PA; QL (1.2 EA per 1 day)
<i>fentanyl citrate buccal tablet 800 mcg</i>	Non Preferred	PA; QL (0.9 EA per 1 day)
<i>hydromorphone hcl oral liquid 1 mg/ml</i>	Non Preferred	PA; QL (22.5 ML per 1 day)
<i>hydromorphone hcl rectal suppository 3 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>levorphanol tartrate oral tablet 2 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>levorphanol tartrate oral tablet 3 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>meperidine hcl oral solution 50 mg/5ml</i>	Non Preferred	PA; QL (90 ML per 1 day)
<i>meperidine hcl oral tablet 50 mg</i>	Non Preferred	PA; QL (18 EA per 1 day)
<i>morphine sulfate rectal suppository 10 mg</i>	Non Preferred	PA; QL (9 EA per 1 day)
<i>morphine sulfate rectal suppository 20 mg</i>	Non Preferred	PA; QL (4.5 EA per 1 day)
<i>morphine sulfate rectal suppository 30 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate rectal suppository 5 mg</i>	Non Preferred	PA; QL (18 EA per 1 day)
<i>nalocet oral tablet 2.5-300 mg</i>	Non Preferred	PA; QL (12 EA per 1 day)
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	Non Preferred	PA; QL (3 ML per 1 day)
<i>oxymorphone hcl oral tablet 10 mg</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>oxymorphone hcl oral tablet 5 mg</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	Non Preferred	PA; QL (4.9 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>tramadol hcl oral solution 5 mg/ml</i>	Non Preferred	PA; QL (40 ML per 1 day); AGE (Min 12 Years)
<i>tramadol hcl oral tablet 100 mg</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 12 Years)
<i>tramadol hcl oral tablet 25 mg</i>	Non Preferred	PA; QL (8 EA per 1 day)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1600 MCG, 400 MCG, 800 MCG (<i>fentanyl citrate</i>)	Non Preferred	PA
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	Non Preferred	PA; AGE (Min 12 Years)
DILAUDID ORAL LIQUID 1 MG/ML (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (22.5 ML per 1 day)
DILAUDID ORAL TABLET 2 MG (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (11.2 EA per 1 day)
DILAUDID ORAL TABLET 4 MG (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (5.6 EA per 1 day)
DILAUDID ORAL TABLET 8 MG (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (2.8 EA per 1 day)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg)	Non Preferred	PA; QL (6 EA per 1 day)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 5-325 Mg)	Non Preferred	PA; QL (12 EA per 1 day)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 7.5-325 Mg)	Non Preferred	PA; QL (8 EA per 1 day)
FENTORA BUCCAL TABLET 100 MCG (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (7.2 EA per 1 day)
FENTORA BUCCAL TABLET 200 MCG (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (3.6 EA per 1 day)
FENTORA BUCCAL TABLET 400 MCG (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (1.8 EA per 1 day)
FENTORA BUCCAL TABLET 600 MCG (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (1.2 EA per 1 day)
FENTORA BUCCAL TABLET 800 MCG (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (0.9 EA per 1 day)
FIORICET/CODEINE ORAL CAPSULE 50-300-40-30 MG (<i>butalbital-apap-caff-cod</i>)	Non Preferred	PA; AGE (Min 12 Years)
NUCYNTA ORAL TABLET 100 MG (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (2.25 EA per 1 day)
NUCYNTA ORAL TABLET 50 MG (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (4.5 EA per 1 day)
NUCYNTA ORAL TABLET 75 MG (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
PERCOCET ORAL TABLET 10-325 MG (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (6 EA per 1 day)
PERCOCET ORAL TABLET 2.5-325 MG, 5-325 MG (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (12 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
PERCOCET ORAL TABLET 7.5-325 MG (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (8 EA per 1 day)
PROLATE ORAL SOLUTION 10-300 MG/5ML (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (60 ML per 1 day)
PROLATE ORAL TABLET 10-300 MG (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (6 EA per 1 day)
PROLATE ORAL TABLET 5-300 MG (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (12 EA per 1 day)
PROLATE ORAL TABLET 7.5-300 MG (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (8 EA per 1 day)
QDOLO ORAL SOLUTION 5 MG/ML (<i>tramadol hcl</i>)	Non Preferred	PA; QL (40 ML per 1 day); AGE (Min 12 Years)
ROXICODONE ORAL TABLET 15 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
ROXICODONE ORAL TABLET 30 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 15 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 30 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 5 MG (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (12 EA per 1 day)
SEGLENTIS ORAL TABLET 56-44 MG (<i>celecoxib-tramadol hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
OTIC [OPEN CLASS]		
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	Preferred	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	Preferred	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	Preferred	
<i>ofloxacin otic solution 0.3 %</i>	Preferred	
CIPRODEX OTIC SUSPENSION 0.3-0.1 % (<i>ciprofloxacin-dexamethasone</i>)	Preferred	
<i>ciprofloxacin hcl otic solution 0.2 %</i>	Non Preferred	PA
<i>ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %</i>	Non Preferred	PA
CIPRO HC OTIC SUSPENSION 0.2-1 % (<i>ciprofloxacin-hydrocortisone</i>)	Non Preferred	PA
PANCREATIC ENZYMES [OPEN CLASS]		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; 90-day fill allowed after two 1-month fills
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; 90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 60000-189600 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
PHOSPHATE BINDERS [OPEN CLASS]		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>calcium acetate (phos binder) tablet 667 mg oral (otc)</i>	Preferred	
<i>calcium acetate (phos binder) tablet 667 mg oral (rx)</i>	Preferred	
<i>calcium acetate oral tablet 667 mg</i>	Preferred	
<i>calcium acetate oral tablet 668 (169 ca) mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lanthanum carbonate oral tablet chewable 500 mg, 750 mg</i>	Preferred	
<i>sevelamer carbonate oral tablet 800 mg</i>	Preferred	90-day fill allowed after two 1-month fills
CALPHRON ORAL TABLET 667 MG (<i>calcium acetate (phos binder)</i>)	Preferred	
<i>lanthanum carbonate oral tablet chewable 1000 mg</i>	Non Preferred	PA
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	Non Preferred	PA
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	Non Preferred	PA
AURYXIA ORAL TABLET 1 GM 210 MG(Fe) (<i>ferric citrate</i>)	Non Preferred	PA
FOSRENOL ORAL PACKET 1000 MG, 750 MG (<i>lanthanum carbonate</i>)	Non Preferred	PA
FOSRENOL ORAL TABLET CHEWABLE 1000 MG, 500 MG, 750 MG (<i>lanthanum carbonate</i>)	Non Preferred	PA
MAGNEBIND 400 ORAL TABLET 80-115 MG (<i>calcium carb-magnesium carb</i>)	Non Preferred	PA
PHOSLYRA ORAL SOLUTION 667 MG/5ML (<i>calcium acetate (phos binder)</i>)	Non Preferred	PA
REVELA ORAL PACKET 0.8 GM, 2.4 GM (<i>sevelamer carbonate</i>)	Non Preferred	PA
REVELA ORAL TABLET 800 MG (<i>sevelamer carbonate</i>)	Non Preferred	PA
VELPHORO ORAL TABLET CHEWABLE 500 MG (<i>sucroferric oxyhydroxide</i>)	Non Preferred	PA
XPHOZAH ORAL TABLET 20 MG, 30 MG (<i>tenapanor hcl (ckd)</i>)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
PLATELET INHIBITORS [OPEN CLASS]		
<i>clopidogrel bisulfate oral tablet 300 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
BRILINTA ORAL TABLET 60 MG, 90 MG (<i>ticagrelor</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	Non Preferred	PA
EFFIENT ORAL TABLET 10 MG, 5 MG (<i>prasugrel hcl</i>)	Non Preferred	PA
PLAVIX ORAL TABLET 75 MG (<i>clopidogrel bisulfate</i>)	Non Preferred	PA
PROGESTATIONAL AGENTS [CLOSED CLASS]		
<i>hydroxyprogesterone caproate intramuscular solution 1.25 gm/5ml</i>	Preferred	
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	
<i>norethindrone acetate oral tablet 5 mg</i>	Preferred	
<i>progesterone intramuscular oil 50 mg/ml</i>	Preferred	
<i>progesterone oral capsule 100 mg, 200 mg</i>	Preferred	
<i>norethindrone acetate (Gallifrey Oral Tablet 5 Mg)</i>	Preferred	
AYGESTIN ORAL TABLET 5 MG (<i>norethindrone acetate</i>)	Non Preferred	PA
CRINONE VAGINAL GEL 4 %, 8 % (<i>progesterone</i>)	Non Preferred	PA
PROMETRIUM ORAL CAPSULE 100 MG, 200 MG (<i>progesterone</i>)	Non Preferred	PA
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA
PROGESTINS USED FOR CACHEXIA [OPEN CLASS]		
<i>megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml</i>	Preferred	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	Preferred	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	Non Preferred	PA
PROTON PUMP INHIBITORS [OPEN CLASS]		
<i>acid reducer oral capsule delayed release 20.6 (20 base) mg</i>	Preferred	QL (4 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 20 mg oral (otc)</i>	Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 20 mg oral (rx)</i>	Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium oral capsule delayed release 40 mg</i>	Preferred	QL (2 EA per 1 day)
<i>ft acid reducer oral capsule delayed release 15 mg</i>	Preferred	QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp esomeprazole magnesium oral capsule delayed release 20 mg</i>	Preferred	QL (2 EA per 1 day)
<i>gnp lansoprazole oral capsule delayed release 15 mg</i>	Preferred	QL (2 EA per 1 day)
<i>gnp omeprazole oral capsule delayed release 20.6 (20 base) mg</i>	Preferred	QL (4 EA per 1 day)
<i>gnp omeprazole oral tablet delayed release dispersible 20 mg</i>	Preferred	QL (4 EA per 1 day)
<i>goodsense lansoprazole oral capsule delayed release 15 mg</i>	Preferred	QL (2 EA per 1 day)
<i>hm esomeprazole magnesium dr oral capsule delayed release 20 mg</i>	Preferred	QL (2 EA per 1 day)
<i>lansoprazole capsule delayed release 15 mg oral (otc)</i>	Preferred	QL (2 EA per 1 day)
<i>lansoprazole capsule delayed release 15 mg oral (rx)</i>	Preferred	QL (2 EA per 1 day)
<i>lansoprazole oral capsule delayed release 30 mg</i>	Preferred	QL (2 EA per 1 day)
<i>omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg</i>	Preferred	QL (4 EA per 1 day)
<i>omeprazole magnesium oral tablet delayed release 20 mg</i>	Preferred	QL (4 EA per 1 day)
<i>omeprazole oral capsule delayed release 10 mg, 40 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>omeprazole oral capsule delayed release 20 mg</i>	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>omeprazole oral tablet delayed release dispersible 20 mg</i>	Preferred	QL (4 EA per 1 day)
<i>pantoprazole sodium oral packet 40 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>sm esomeprazole magnesium oral capsule delayed release 20 mg</i>	Preferred	QL (2 EA per 1 day)
<i>sm lansoprazole oral capsule delayed release 15 mg</i>	Preferred	QL (2 EA per 1 day)
GOODSENSE ESOMEPRAZOLE ORAL CAPSULE DELAYED RELEASE 20 MG (<i>esomeprazole magnesium</i>)	Preferred	QL (2 EA per 1 day)
PROTONIX ORAL PACKET 40 MG (<i>pantoprazole sodium</i>)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>dexlansoprazole oral capsule delayed release 30 mg, 60 mg</i>	Non Preferred	PA
<i>esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>esomeprazole magnesium oral tablet delayed release 20 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>ft omeprazole oral tablet delayed release 20 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>gnp omeprazole oral tablet delayed release 20 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>goodsense lansoprazole oral tablet delayed release dispersible 15 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>goodsense omeprazole oral capsule 20-1100 mg</i>	Non Preferred	PA
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>omeprazole oral tablet delayed release 20 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>omeprazole-sodium bicarbonate oral capsule 20-1100 mg, 40-1100 mg</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate oral packet 20-1680 mg, 40-1680 mg</i>	Non Preferred	PA
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	Non Preferred	PA
<i>sm omeprazole oral tablet delayed release 20 mg</i>	Non Preferred	PA; QL (4 EA per 1 day)
ACIPHEX ORAL TABLET DELAYED RELEASE 20 MG (<i>rabeprazole sodium</i>)	Non Preferred	PA
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG (<i>dexlansoprazole</i>)	Non Preferred	PA
KONVOMEPRAL ORAL SUSPENSION RECONSTITUTED 2-84 MG/ML (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA; QL (2 ML per 1 day)
NEXIUM ORAL CAPSULE DELAYED RELEASE 20 MG, 40 MG (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 40 MG, 5 MG (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID 24HR ORAL CAPSULE DELAYED RELEASE 15 MG (<i>lansoprazole</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG (<i>lansoprazole</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID SOLUTAB ORAL TABLET DELAYED RELEASE DISPERSIBLE 15 MG, 30 MG (<i>lansoprazole</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (<i>omeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PROTONIX ORAL TABLET DELAYED RELEASE 20 MG, 40 MG (<i>pantoprazole sodium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
ZEGERID ORAL CAPSULE 20-1100 MG, 40-1100 MG (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
ZEGERID ORAL PACKET 20-1680 MG, 40-1680 MG (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
PSORIASIS: TOPICAL [OPEN CLASS]		
<i>calcipotriene external cream 0.005 %</i>	Preferred	
<i>calcipotriene external ointment 0.005 %</i>	Preferred	
<i>calcipotriene external solution 0.005 %</i>	Preferred	
<i>calcipotriene external foam 0.005 %</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>calcipotriene-betameth diprop external ointment 0.005-0.064 %</i>	Non Preferred	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	Non Preferred	PA
<i>calcitriol external ointment 3 mcg/gm</i>	Non Preferred	PA; AGE (Max 18 Years)
BESER EXTERNAL KIT 0.05 % (<i>fluticasone-emollient</i>)	Non Preferred	PA
DUOBRII EXTERNAL LOTION 0.01-0.045 % (<i>halobetasol prop-tazarotene</i>)	Non Preferred	PA
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	Non Preferred	PA; AGE (Min 18 Years)
SORILUX EXTERNAL FOAM 0.005 % (<i>calcipotriene</i>)	Non Preferred	PA
TACLONEX EXTERNAL OINTMENT 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	Non Preferred	PA
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (<i>calcipotriene-betameth diprop</i>)	Non Preferred	PA
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZORYVE EXTERNAL CREAM 0.3 % (<i>roflumilast</i>)	Non Preferred	PA; AGE (Min 6 Years)
PULMONARY ARTERIAL HYPERTENSION [OPEN CLASS]		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	Preferred	SP; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	Preferred	SP; QL (2 EA per 1 day)
<i>sildenafil citrate oral suspension reconstituted 10 mg/ml</i>	Preferred	SP; PA; AGE (Min 1 Years)
<i>sildenafil citrate oral tablet 20 mg</i>	Preferred	SP; PA; AGE (Min 1 Years)
<i>tadalafil (pah) oral tablet 20 mg</i>	Preferred	SP; PA; AGE (Min 18 Years)
<i>tadalafil (pah) (Alyq Oral Tablet 20 Mg)</i>	Preferred	SP; PA; AGE (Min 18 Years)
TRACLEER ORAL TABLET 125 MG, 62.5 MG (<i>bosentan</i>)	Preferred	SP; QL (2 EA per 1 day)
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (<i>iloprost</i>)	Preferred	SP
ADCIRCA ORAL TABLET 20 MG (<i>tadalafil (pah)</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	Non Preferred	SP; PA
LETAIRIS ORAL TABLET 10 MG, 5 MG (<i>ambrisentan</i>)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LIQREV ORAL SUSPENSION 10 MG/ML (<i>sildenafil citrate</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	Non Preferred	SP; PA
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG (<i>macitentan-tadalafil</i>)	Non Preferred	SP; PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	Non Preferred	SP; PA
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	Non Preferred	SP; PA
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	Non Preferred	SP; PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	Non Preferred	SP; PA
REVATIO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (<i>sildenafil citrate</i>)	Non Preferred	SP; PA; AGE (Min 1 Years)
REVATIO ORAL TABLET 20 MG (<i>sildenafil citrate</i>)	Non Preferred	SP; PA; AGE (Min 1 Years)
TADLIQ ORAL SUSPENSION 20 MG/5ML (<i>tadalafil (pah)</i>)	Non Preferred	SP; PA; AGE (Min 18 Years)
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	Non Preferred	SP; PA
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	Non Preferred	SP; PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (<i>treprostinil</i>)	Non Preferred	SP; PA
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG, 16 & 32 & 48 MCG (<i>treprostinil</i>)	Non Preferred	SP; PA
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	Non Preferred	SP; PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	Non Preferred	SP; PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	Non Preferred	SP; PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	Non Preferred	SP; PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	Non Preferred	SP; PA
QUINOLONES: ORAL [OPEN CLASS]		
<i>ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg</i>	Preferred	
<i>ciprofloxacin oral suspension reconstituted 250 mg/5ml (5%), 500 mg/5ml (10%)</i>	Preferred	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	Preferred	
<i>levofloxacin oral solution 25 mg/ml</i>	Non Preferred	PA
<i>moxifloxacin hcl oral tablet 400 mg</i>	Non Preferred	PA
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Non Preferred	PA
BAXDELA ORAL TABLET 450 MG (<i>delafloxacin meglumine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (<i>ciprofloxacin</i>)	Non Preferred	PA
CIPRO ORAL TABLET 250 MG, 500 MG (<i>ciprofloxacin hcl</i>)	Non Preferred	PA
ROSACEA AGENTS: TOPICAL [OPEN CLASS]		
<i>ivermectin external cream 1 %</i>	Preferred	
<i>metronidazole external cream 0.75 %</i>	Preferred	
<i>metronidazole external gel 0.75 %</i>	Preferred	
<i>metronidazole external lotion 0.75 %</i>	Preferred	
<i>metronidazole gel 1 % external</i>	Preferred	
<i>metronidazole (Rosadan External Cream 0.75 %)</i>	Preferred	
<i>metronidazole (Rosadan External Gel 0.75 %)</i>	Preferred	
<i>azelaic acid external gel 15 %</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>brimonidine tartrate external gel 0.33 %</i>	Non Preferred	PA
<i>metronidazole gel 1 % external</i>	Non Preferred	PA
FINACEA EXTERNAL FOAM 15 % (<i>azelaic acid</i>)	Non Preferred	PA; AGE (Min 18 Years)
FINACEA EXTERNAL GEL 15 % (<i>azelaic acid</i>)	Non Preferred	PA; AGE (Min 18 Years)
NORITATE EXTERNAL CREAM 1 % (<i>metronidazole</i>)	Non Preferred	PA
RHOFADE EXTERNAL CREAM 1 % (<i>oxymetazoline hcl</i>)	Non Preferred	PA
ROSADAN EXTERNAL KIT 0.75 % CREAM, 0.75 % GEL (<i>metronidazole-cleanser</i>)	Non Preferred	PA
SECOND GENERATION ANTIHISTAMINES AND COMBINATIONS [OPEN CLASS]		
<i>12hr allergy & congestion oral tablet extended release 12 hour 60-120 mg</i>	Preferred	
<i>all day allergy childrens oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>all day allergy oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>allergy childrens oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>allergy rel child (loratadine) oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>allergy relief (loratadine) oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>allergy relief cetirizine oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>allergy relief childrens oral solution 1 mg/ml</i>	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
<i>allergy relief oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>allergy relief/indoor/outdoor oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cetirizine hcl allergy child oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cetirizine hcl childrens alrgy oral solution 1 mg/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>cetirizine hcl oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>childrens loratadine oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>fexofenadine-pseudoephed er oral tablet extended release 12 hour 60-120 mg</i>	Preferred	
<i>ft all day allergy 24 hour oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft all day allergy childrens oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft all day allergy oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft all day allergy relief oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft allergy & congestion-d 12hr oral tablet extended release 12 hour 60-120 mg</i>	Preferred	
<i>ft allergy childrens oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>ft allergy relief cetirizine oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft allergy relief childrens oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft allergy relief loratadine oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft allergy relief oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp all day allergy childrens oral solution 1 mg/ml, 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp all day allergy oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp allergy relief 24 hr oral tablet 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp fexofenadine/pse er oral tablet extended release 12 hour 60-120 mg</i>	Preferred	
<i>gnp loratadine childrens oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>gnp loratadine oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>gnp loratadine oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp loratadine oral tablet dispersible 10 mg</i>	Preferred	
<i>goodsense all day allergy oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense all day allergy oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense allergy relief child oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>goodsense allergy relief oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hm all day allergy childrens oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hm all day allergy oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hm allergy relief (cetirizine) oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hm cetirizine hcl oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hm loratadine oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>loratadine childrens oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>loratadine oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>loratadine oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>loratadine oral tablet dispersible 10 mg</i>	Preferred	
<i>sm all day allergy childrens oral solution 1 mg/ml, 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm all day allergy oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm all day allergy relief oral tablet 10 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm allergy childrens oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>sm loratadine oral solution 5 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>12hr allergy relief oral tablet 60 mg</i>	Non Preferred	PA
<i>24hr allergy relief oral tablet 180 mg</i>	Non Preferred	PA
<i>all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>allergy 24-hr oral tablet 180 mg</i>	Non Preferred	PA
<i>allergy childrens oral suspension 30 mg/5ml</i>	Non Preferred	PA
<i>allergy relief (cetirizine) oral capsule 10 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>allergy relief d oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>allergy relief d-12 oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>allergy relief d-24 oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>allergy relief oral tablet 180 mg</i>	Non Preferred	PA
<i>allergy relief/nasal decongest oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>allergy relief/nasal decongest oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>cetirizine hcl childrens oral solution 5 mg/5ml</i>	Non Preferred	PA
<i>cetirizine hcl oral tablet chewable 10 mg, 5 mg</i>	Non Preferred	PA
<i>cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>desloratadine oral tablet 5 mg</i>	Non Preferred	PA
<i>desloratadine oral tablet dispersible 2.5 mg, 5 mg</i>	Non Preferred	PA
<i>fexofenadine hcl oral tablet 180 mg, 60 mg</i>	Non Preferred	PA
<i>fexofenadine-pseudoephed er oral tablet extended release 24 hour 180-240 mg</i>	Non Preferred	PA
<i>ft all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>ft allergy d-12 hour oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>ft allergy relief 12 hour oral tablet 60 mg</i>	Non Preferred	PA
<i>ft allergy relief 24 hour oral tablet 180 mg</i>	Non Preferred	PA
<i>ft allergy relief childrens oral tablet chewable 5 mg</i>	Non Preferred	PA; AGE (Min 2 Years)
<i>ft allergy relief oral tablet 180 mg</i>	Non Preferred	PA
<i>ft allergy relief-d oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>gnp all day allergy relief oral capsule 10 mg</i>	Non Preferred	PA
<i>gnp all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp allergy & congestion oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>gnp allergy relief oral tablet 180 mg</i>	Non Preferred	PA
<i>gnp allergy/congestion relief oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>goodsense all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>goodsense aller-ease oral tablet 180 mg</i>	Non Preferred	PA
<i>hm allergy relief oral tablet 180 mg, 60 mg</i>	Non Preferred	PA
<i>hm allergy relief/nasal decong oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	Non Preferred	PA
<i>loratadine childrens oral tablet chewable 5 mg</i>	Non Preferred	PA; AGE (Min 2 Years)
<i>loratadine-d 12hr oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
<i>sm all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>sm allergy relief oral tablet 60 mg</i>	Non Preferred	PA
<i>sm fexofenadine hcl oral tablet 180 mg</i>	Non Preferred	PA
<i>sm loratadine d 12hr oral tablet extended release 12 hour 5-120 mg</i>	Non Preferred	PA
<i>sm lorata-dine d oral tablet extended release 24 hour 10-240 mg</i>	Non Preferred	PA
CLARINEX ORAL TABLET 5 MG (<i>desloratadine</i>)	Non Preferred	PA
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (<i>desloratadine-pseudoephedrine</i>)	Non Preferred	PA
SEDATIVES: HYPNOTICS [OPEN CLASS]		
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>temazepam oral capsule 15 mg, 30 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>estazolam oral tablet 1 mg, 2 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>flurazepam hcl oral capsule 15 mg, 30 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>quazepam oral tablet 15 mg</i>	Non Preferred	PA
<i>ramelteon oral tablet 8 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>tasimelteon oral capsule 20 mg</i>	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 16 Years)
<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate oral capsule 7.5 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN CR ORAL TABLET EXTENDED RELEASE 12.5 MG, 6.25 MG (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN ORAL TABLET 10 MG, 5 MG (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DAYVIGO ORAL TABLET 10 MG, 5 MG (<i>lemborexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DORAL ORAL TABLET 15 MG (<i>quazepam</i>)	Non Preferred	PA
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
HALCION ORAL TABLET 0.25 MG (<i>triazolam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (<i>tasimelteon</i>)	Non Preferred	PA; QL (5 ML per 1 day); AGE (Min 3 Years and Max 15 Years)
HETLIOZ ORAL CAPSULE 20 MG (<i>tasimelteon</i>)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 16 Years)
LUNESTA ORAL TABLET 1 MG, 2 MG, 3 MG (<i>eszopiclone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QUVIVIQ ORAL TABLET 25 MG, 50 MG (<i>daridorexant hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (<i>temazepam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
ROZEREM ORAL TABLET 8 MG (<i>ramelteon</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SICKLE CELL ANEMIA TREATMENTS [CLOSED CLASS]		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (<i>hydroxyurea</i>)	Preferred	AGE (Min 18 Years)
ENDARI ORAL PACKET 5 GM (<i>glutamine (sickle cell)</i>)	Preferred	SP; AGE (Min 5 Years)
ADAKVEO INTRAVENOUS SOLUTION 100 MG/10ML (<i>crizanlizumab-tmca</i>)	Non Preferred	PA; AGE (Min 16 Years)
SIKLOS ORAL TABLET 100 MG, 1000 MG (<i>hydroxyurea</i>)	Non Preferred	SP; PA; AGE (Min 2 Years)
SKELETAL MUSCLE RELAXANTS [OPEN CLASS]		
<i>baclofen oral solution 5 mg/5ml</i>	Preferred	AGE (Min 12 Years)
<i>baclofen oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	Preferred	AGE (Min 12 Years)
<i>chlorzoxazone oral tablet 250 mg, 375 mg, 500 mg, 750 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 18 Years)
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	Preferred	QL (3 EA per 1 day); AGE (Min 15 Years)
<i>cyclobenzaprine hcl oral tablet 7.5 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 15 Years)
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 5 Years)
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	Preferred	AGE (Min 16 Years)
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years)
<i>tizanidine hcl oral tablet 2 mg</i>	Preferred	QL (4 EA per 1 day); AGE (Min 18 Years)
<i>tizanidine hcl oral tablet 4 mg</i>	Preferred	QL (9 EA per 1 day); AGE (Min 18 Years)
<i>baclofen oral solution 10 mg/5ml</i>	Non Preferred	PA; QL (40 ML per 1 day); AGE (Min 12 Years)
<i>baclofen oral suspension 25 mg/5ml</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>carisoprodol oral tablet 250 mg, 350 mg</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 16 Years)
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	Non Preferred	PA; AGE (Min 16 Years)
<i>cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg, 30 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 15 Years)
<i>metaxalone oral tablet 400 mg, 800 mg</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 13 Years)
<i>norgesic forte oral tablet 50-770-60 mg</i>	Non Preferred	PA
<i>orphenadrine-asa-caffeine oral tablet 50-770-60 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>tizanidine hcl oral capsule 2 mg</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
<i>tizanidine hcl oral capsule 4 mg</i>	Non Preferred	PA; QL (9 EA per 1 day); AGE (Min 18 Years)
<i>tizanidine hcl oral capsule 6 mg</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
AMRIX ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>cyclobenzaprine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 15 Years)
DANTRIUM ORAL CAPSULE 25 MG (<i>dantrolene sodium</i>)	Non Preferred	PA; AGE (Min 5 Years)
<i>cyclobenzaprine hcl</i> (Fexmid Oral Tablet 7.5 Mg)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 15 Years)
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (<i>baclofen</i>)	Non Preferred	PA; AGE (Min 12 Years)
<i>chlorzoxazone</i> (Lorzone Oral Tablet 375 Mg, 750 Mg)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
LYVISPAH ORAL PACKET 10 MG, 20 MG, 5 MG (<i>baclofen</i>)	Non Preferred	PA; AGE (Min 12 Years)
<i>orphenadrine-aspirin-caffeine</i> (Norgesic Oral Tablet 25-385-30 Mg)	Non Preferred	PA
<i>orphenadrine-aspirin-caffeine</i> (Orphengesic Forte Oral Tablet 50-770-60 Mg)	Non Preferred	PA
SOMA ORAL TABLET 250 MG, 350 MG (<i>carisoprodol</i>)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 16 Years)
TANLOR ORAL TABLET 1000 MG (<i>methocarbamol</i>)	Non Preferred	PA
ZANAFLEX ORAL CAPSULE 2 MG (<i>tizanidine hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
ZANAFLEX ORAL CAPSULE 4 MG (<i>tizanidine hcl</i>)	Non Preferred	PA; QL (9 EA per 1 day); AGE (Min 18 Years)
ZANAFLEX ORAL CAPSULE 6 MG (<i>tizanidine hcl</i>)	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
ZANAFLEX ORAL TABLET 4 MG (<i>tizanidine hcl</i>)	Non Preferred	PA; QL (9 EA per 1 day); AGE (Min 18 Years)
SMOKING CESSATION [OPEN CLASS]		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>ft nicotine mouth/throat gum 2 mg, 4 mg</i>	Preferred	
<i>ft nicotine mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>gnp nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>gnp nicotine mouth/throat gum 2 mg, 4 mg</i>	Preferred	
<i>gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	Preferred	
<i>gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	Preferred	
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	Preferred	
<i>goodsense nicotine mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>hm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>hm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	Preferred	
<i>nicotine mini mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	Preferred	
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	Preferred	
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	Preferred	
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	Preferred	
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	Preferred	
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	Preferred	
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	Preferred	
<i>sm nicotine mouth/throat gum 4 mg</i>	Preferred	
<i>sm nicotine mouth/throat lozenge 2 mg</i>	Preferred	
<i>sm nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	Preferred	
<i>sm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	Preferred	
<i>sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	Preferred	
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	Preferred	
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	Preferred	
<i>varenicline tartrate(continue) oral tablet 1 mg</i>	Preferred	
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (<i>varenicline tartrate</i>)	Preferred	
CHANTIX ORAL TABLET 1 MG (<i>varenicline tartrate</i>)	Preferred	
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (<i>varenicline tartrate</i>)	Preferred	
NICOTROL INHALATION INHALER 10 MG (<i>nicotine</i>)	Non Preferred	PA
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	Non Preferred	PA
STEROIDS: TOPICAL, HIGH POTENCY [OPEN CLASS]		
<i>betamethasone dipropionate aug external cream 0.05 %</i>	Preferred	
<i>betamethasone valerate external cream 0.1 %</i>	Preferred	
<i>betamethasone valerate external lotion 0.1 %</i>	Preferred	
<i>betamethasone valerate external ointment 0.1 %</i>	Preferred	
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	Preferred	
<i>triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %</i>	Preferred	
<i>triamcinolone in absorbase external ointment 0.05 %</i>	Preferred	
<i>amcinonide external cream 0.1 %</i>	Non Preferred	PA
<i>betamethasone dipropionate aug external gel 0.05 %</i>	Non Preferred	PA
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	Non Preferred	PA
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	Non Preferred	PA
<i>betamethasone dipropionate external cream 0.05 %</i>	Non Preferred	PA
<i>betamethasone dipropionate external lotion 0.05 %</i>	Non Preferred	PA
<i>betamethasone dipropionate external ointment 0.05 %</i>	Non Preferred	PA
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	Non Preferred	PA
<i>desoximetasone external gel 0.05 %</i>	Non Preferred	PA
<i>desoximetasone external liquid 0.25 %</i>	Non Preferred	PA
<i>desoximetasone external ointment 0.05 %, 0.25 %</i>	Non Preferred	PA
<i>diflorasone diacetate external cream 0.05 %</i>	Non Preferred	PA
<i>diflorasone diacetate external ointment 0.05 %</i>	Non Preferred	PA
<i>fluocinonide emulsified base external cream 0.05 %</i>	Non Preferred	PA
<i>fluocinonide external cream 0.05 %, 0.1 %</i>	Non Preferred	PA
<i>fluocinonide external gel 0.05 %</i>	Non Preferred	PA
<i>fluocinonide external ointment 0.05 %</i>	Non Preferred	PA
<i>fluocinonide external solution 0.05 %</i>	Non Preferred	PA
<i>halcinonide external cream 0.1 %</i>	Non Preferred	PA
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	Non Preferred	PA
DIPROLENE EXTERNAL OINTMENT 0.05 % (<i>betamethasone dipropionate aug</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
HALOG EXTERNAL CREAM 0.1 % (<i>halcinonide</i>)	Non Preferred	PA
HALOG EXTERNAL OINTMENT 0.1 % (<i>halcinonide</i>)	Non Preferred	PA
HALOG EXTERNAL SOLUTION 0.1 % (<i>halcinonide</i>)	Non Preferred	PA
KENALOG EXTERNAL AEROSOL SOLUTION 0.147 MG/GM (<i>triamcinolone acetonide</i>)	Non Preferred	PA
TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT EXTERNAL GEL 0.05 % (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT SPRAY EXTERNAL LIQUID 0.25 % (<i>desoximetasone</i>)	Non Preferred	PA
VANOS EXTERNAL CREAM 0.1 % (<i>fluocinonide</i>)	Non Preferred	PA
STERIODS: TOPICAL, LOW POTENCY [OPEN CLASS]		
<i>anti-itch maximum strength external cream 1 %</i>	Preferred	
<i>ft itch relief max strength external cream 1 %</i>	Preferred	
<i>ft itch relief max strength external ointment 1 %</i>	Preferred	
<i>ft itch relief/aloe max str external cream 1 %</i>	Preferred	
<i>gnp hydrocortisone external cream 0.5 %</i>	Preferred	
<i>gnp hydrocortisone max st external ointment 1 %</i>	Preferred	
<i>gnp hydrocortisone plus external cream 1 %</i>	Preferred	
<i>gnp hydrocortisone/aloe external cream 1 %</i>	Preferred	
<i>hm hydrocortisone plus external cream 1 %</i>	Preferred	
<i>hm hydrocortisone-aloe max st external cream 1 %</i>	Preferred	
<i>hydrocortisone (perianal) external cream 2.5 %</i>	Preferred	
<i>hydrocortisone acetate external cream 1 %</i>	Preferred	
<i>hydrocortisone acetate external ointment 1 %</i>	Preferred	
<i>hydrocortisone cream 1 % external (otc)</i>	Preferred	
<i>hydrocortisone cream 1 % external (rx)</i>	Preferred	
<i>hydrocortisone external cream 0.5 %, 2.5 %</i>	Preferred	
<i>hydrocortisone external lotion 2.5 %</i>	Preferred	
<i>hydrocortisone external ointment 2.5 %</i>	Preferred	
<i>hydrocortisone max st external cream 1 %</i>	Preferred	
<i>hydrocortisone max st/12 moist external cream 1 %</i>	Preferred	
<i>hydrocortisone ointment 1 % external (otc)</i>	Preferred	
<i>hydrocortisone ointment 1 % external (rx)</i>	Preferred	
<i>hydrocortisone/aloe max str external cream 1 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm hydrocortisone external cream 1 %</i>	Preferred	
<i>sm hydrocortisone max st external ointment 1 %</i>	Preferred	
<i>sm hydrocortisone plus external cream 1 %</i>	Preferred	
<i>hydrocortisone (Proctocort External Cream 1 %)</i>	Preferred	
<i>hydrocortisone (Procto-Med Hc External Cream 2.5 %)</i>	Preferred	
<i>hydrocortisone (Proctosol Hc External Cream 2.5 %)</i>	Preferred	
<i>hydrocortisone (Proctozone-Hc External Cream 2.5 %)</i>	Preferred	
<i>alclometasone dipropionate external cream 0.05 %</i>	Non Preferred	PA
<i>alclometasone dipropionate external ointment 0.05 %</i>	Non Preferred	PA
<i>desonide external cream 0.05 %</i>	Non Preferred	PA
<i>desonide external lotion 0.05 %</i>	Non Preferred	PA
<i>desonide external ointment 0.05 %</i>	Non Preferred	PA
<i>fluocinolone acetonide body external oil 0.01 %</i>	Non Preferred	PA
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	Non Preferred	PA
<i>hydrocortisone complete kit external therapy pack 2 %</i>	Non Preferred	PA
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	Non Preferred	PA
DERMA-SMOOTH/FS BODY EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	Non Preferred	PA
DERMA-SMOOTH/FS SCALP EXTERNAL OIL 0.01 % (<i>fluocinolone acetonide</i>)	Non Preferred	PA
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	Non Preferred	PA
STERIODS: TOPICAL, MEDIUM POTENCY [OPEN CLASS]		
<i>fluticasone propionate external cream 0.05 %</i>	Preferred	
<i>fluticasone propionate external ointment 0.005 %</i>	Preferred	
<i>mometasone furoate external cream 0.1 %</i>	Preferred	
<i>mometasone furoate external ointment 0.1 %</i>	Preferred	
<i>mometasone furoate external solution 0.1 %</i>	Preferred	
<i>betamethasone valerate external foam 0.12 %</i>	Non Preferred	PA
<i>clocortolone pivalate external cream 0.1 %</i>	Non Preferred	PA
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>fluocinolone acetonide external ointment 0.025 %</i>	Non Preferred	PA
<i>fluocinolone acetonide external solution 0.01 %</i>	Non Preferred	PA
<i>flurandrenolide external lotion 0.05 %</i>	Non Preferred	PA
<i>flurandrenolide external ointment 0.05 %</i>	Non Preferred	PA
<i>fluticasone propionate external lotion 0.05 %</i>	Non Preferred	PA
<i>hydrocortisone butyr lipo base external cream 0.1 %</i>	Non Preferred	PA
<i>hydrocortisone butyrate external cream 0.1 %</i>	Non Preferred	PA
<i>hydrocortisone butyrate external lotion 0.1 %</i>	Non Preferred	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	Non Preferred	PA
<i>hydrocortisone butyrate external solution 0.1 %</i>	Non Preferred	PA
<i>hydrocortisone valerate external cream 0.2 %</i>	Non Preferred	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	Non Preferred	PA
<i>prednicarbate external cream 0.1 %</i>	Non Preferred	PA
<i>prednicarbate external ointment 0.1 %</i>	Non Preferred	PA
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	Non Preferred	PA
<i>fluticasone propionate (Beser External Lotion 0.05 %)</i>	Non Preferred	PA
CLODERM EXTERNAL CREAM 0.1 % (<i>clocortolone pivalate</i>)	Non Preferred	PA
LOCOID EXTERNAL LOTION 0.1 % (<i>hydrocortisone butyrate</i>)	Non Preferred	PA
LOCOID LIPOCREAM EXTERNAL CREAM 0.1 % (<i>hydrocortisone butyr lipo base</i>)	Non Preferred	PA
<i>triamcinolone acetonide</i> (Oralone Mouth/Throat Paste 0.1 %)	Non Preferred	PA
PANDEL EXTERNAL CREAM 0.1 % (<i>hydrocortisone probutate</i>)	Non Preferred	PA
SYNALAR (CREAM) EXTERNAL KIT 0.025 % (<i>fluocinolone-emollient</i>)	Non Preferred	PA
SYNALAR (OINTMENT) EXTERNAL KIT 0.025 % (<i>fluocinolone-emollient</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SYNALAR EXTERNAL CREAM 0.025 % (<i>fluocinolone acetonide</i>)	Non Preferred	PA
SYNALAR EXTERNAL OINTMENT 0.025 % (<i>fluocinolone acetonide</i>)	Non Preferred	PA
SYNALAR EXTERNAL SOLUTION 0.01 % (<i>fluocinolone acetonide</i>)	Non Preferred	PA
SYNALAR TS EXTERNAL KIT 0.01 % (<i>fluocinolone & cleanser</i>)	Non Preferred	PA
STEROIDS: TOPICAL, VERY HIGH POTENCY [OPEN CLASS]		
<i>clobetasol prop emollient base external cream 0.05 %</i>	Preferred	
<i>clobetasol propionate e external cream 0.05 %</i>	Preferred	
<i>clobetasol propionate external cream 0.05 %</i>	Preferred	
<i>clobetasol propionate external gel 0.05 %</i>	Preferred	
<i>clobetasol propionate external ointment 0.05 %</i>	Preferred	
<i>clobetasol propionate external solution 0.05 %</i>	Preferred	
<i>halobetasol propionate external cream 0.05 %</i>	Preferred	
<i>clobetasol propionate emulsion external foam 0.05 %</i>	Non Preferred	PA
<i>clobetasol propionate external foam 0.05 %</i>	Non Preferred	PA
<i>clobetasol propionate external liquid 0.05 %</i>	Non Preferred	PA
<i>clobetasol propionate external lotion 0.05 %</i>	Non Preferred	PA
<i>clobetasol propionate external shampoo 0.05 %</i>	Non Preferred	PA
<i>halobetasol propionate external foam 0.05 %</i>	Non Preferred	PA
<i>halobetasol propionate external ointment 0.05 %</i>	Non Preferred	PA
APEXICON E EXTERNAL CREAM 0.05 % (<i>diflorasone diacet emoll base</i>)	Non Preferred	PA
BRYHALI EXTERNAL LOTION 0.01 % (<i>halobetasol propionate</i>)	Non Preferred	PA
CLODAN EXTERNAL KIT 0.05 % (<i>clobetasol prop & cleanser</i>)	Non Preferred	PA
<i>clobetasol propionate</i> (Clodan External Shampoo 0.05 %)	Non Preferred	PA
IMPEKLO EXTERNAL LOTION 0.15 MG/ACT (0.05%) (<i>clobetasol propionate</i>)	Non Preferred	PA
LEXETTE EXTERNAL FOAM 0.05 % (<i>halobetasol propionate</i>)	Non Preferred	PA
OLUX EXTERNAL FOAM 0.05 % (<i>clobetasol propionate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TEMOVATE EXTERNAL OINTMENT 0.05 % (<i>clobetasol propionate</i>)	Non Preferred	PA
<i>clobetasol propionate emulsion</i> (Tovet External Foam 0.05 %)	Non Preferred	PA
TOVET EXTERNAL KIT 0.05 % (<i>clobetasol emul foam w/moistcr</i>)	Non Preferred	PA
ULTRAVATE EXTERNAL LOTION 0.05 % (<i>halobetasol propionate</i>)	Non Preferred	PA
STIMULANTS AND RELATED AGENTS [CLOSED CLASS]		
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg</i>	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg</i>	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>clonidine hcl er oral tablet extended release 12 hour 0.1 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>modafinil oral tablet 100 mg, 200 mg</i>	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 54 MG (<i>methylphenidate hcl</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
CONCERTA ORAL TABLET EXTENDED RELEASE 36 MG (<i>methylphenidate hcl</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA TRANSDERMAL PATCH 10 MG/9HR, 15 MG/9HR, 20 MG/9HR, 30 MG/9HR (<i>methylphenidate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
SUNOSI ORAL TABLET 150 MG, 75 MG (<i>solriamfetol hcl</i>)	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
<i>methamphetamine hcl oral tablet 5 mg</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 45 mg, 54 mg, 63 mg, 72 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr, 30 mg/9hr</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG, 7.5 MG (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 5 MG (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 25 MG, 30 MG (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (<i>serdexmethylphen-dexmethylphen</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (<i>methylphenidate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG (<i>dextroamphetamine sulfate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR ORAL TABLET CHEWABLE EXTENDED RELEASE 10 MG, 15 MG, 20 MG, 5 MG (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 20 MG, 5 MG (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ORAL TABLET 10 MG, 5 MG (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG, 5 MG (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
INTUNIV ORAL TABLET EXTENDED RELEASE 24 HOUR 1 MG, 2 MG, 3 MG, 4 MG (<i>guanfacine hcl</i>)	Non Preferred	PA
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG, 50 MG (<i>armodafinil</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>dextroamphetamine sulfate</i> (Procentra Oral Solution 5 Mg/5ML)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
PROVIGIL ORAL TABLET 100 MG, 200 MG (<i>modafinil</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (<i>viloxazine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years)
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RELEXXII ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 45 MG, 54 MG, 63 MG, 72 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RELEXXII ORAL TABLET EXTENDED RELEASE 36 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 30 MG, 40 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
STRATTERA ORAL CAPSULE 10 MG, 100 MG, 18 MG, 25 MG, 40 MG, 60 MG, 80 MG (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (<i>lisdexamfetamine dimesylate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (<i>pitolisant hcl</i>)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 18 Years)
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (<i>dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
<i>dextroamphetamine sulfate</i> (Zenedi Oral Tablet 10 Mg, 15 Mg, 2.5 Mg, 20 Mg, 30 Mg, 5 Mg, 7.5 Mg)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
SUPPLEMENTAL		
*ACNE PRODUCTS***		
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Preferred	PA; QL (2 EA per 1 day)
<i>isotretinoin</i> (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
<i>isotretinoin</i> (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>isotretinoin</i> (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
*ALCOHOL DETERRENTS***		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	Preferred	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	Preferred	
*ALTERNATIVE MEDICINE - CO'S***		
<i>co q-10 oral capsule 50 mg</i>	Preferred	
<i>coenzyme q-10 oral capsule 200 mg, 30 mg</i>	Preferred	
<i>sm coenzyme q-10 oral capsule 100 mg</i>	Preferred	
*ALTERNATIVE MEDICINE - ME'S***		
<i>melatonin oral tablet 3 mg, 5 mg</i>	Preferred	
<i>sm melatonin oral tablet 3 mg</i>	Preferred	
*AMINOPENICILLINS***		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	Preferred	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	Preferred	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	Preferred	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	Preferred	
*ANALGESIC COMBINATIONS***		
<i>ft migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>gnp headache relief extra str oral tablet 250-250-65 mg</i>	Preferred	
<i>gnp migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>goodsense migraine formula oral tablet 250-250-65 mg</i>	Preferred	
<i>headache formula oral tablet 250-250-65 mg</i>	Preferred	
<i>headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>hm migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>pain reliever plus oral tablet 250-250-65 mg</i>	Preferred	
<i>sm migraine relief oral tablet 250-250-65 mg</i>	Preferred	
*ANALGESICS OTHER***		
<i>8 hour pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>acetaminophen childrens oral solution 160 mg/5ml</i>	Preferred	
<i>acetaminophen childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>acetaminophen childrens oral tablet chewable 160 mg</i>	Preferred	
<i>acetaminophen er oral tablet extended release 650 mg</i>	Preferred	
<i>acetaminophen extra strength oral tablet 500 mg</i>	Preferred	
<i>acetaminophen infants oral suspension 160 mg/5ml</i>	Preferred	
<i>acetaminophen oral liquid 160 mg/5ml</i>	Preferred	
<i>acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml</i>	Preferred	
<i>acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>acetaminophen oral tablet 325 mg, 500 mg</i>	Preferred	
<i>acetaminophen oral tablet chewable 160 mg</i>	Preferred	
<i>acetaminophen rectal suppository 120 mg, 650 mg</i>	Preferred	
<i>arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>ed-apap oral liquid 160 mg/5ml</i>	Preferred	
<i>ft 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>ft arthritis pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>ft children's pain/fever oral tablet chewable 160 mg</i>	Preferred	
<i>ft pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>ft pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>ft pain relief adult extra st oral tablet 500 mg</i>	Preferred	
<i>ft pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>ft pain relief oral tablet 325 mg</i>	Preferred	
<i>ft pain reliever ex str adult oral tablet 500 mg</i>	Preferred	
<i>gnp 8 hour arthritis relief oral tablet extended release 650 mg</i>	Preferred	
<i>gnp 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>gnp 8 hour pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>gnp acetaminophen oral tablet 325 mg</i>	Preferred	
<i>gnp acetaminophen oral tablet chewable 160 mg</i>	Preferred	
<i>gnp infants pain/fever oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>gnp pain relief oral tablet 325 mg</i>	Preferred	
<i>goodsense arthritis pain oral tablet extended release 650 mg</i>	Preferred	
<i>goodsense pain & fever child oral suspension 160 mg/5ml</i>	Preferred	
<i>goodsense pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>goodsense pain relief extra st oral tablet 500 mg</i>	Preferred	
<i>goodsense pain relief oral tablet 325 mg</i>	Preferred	
<i>hm arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>hm pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>liquid acetaminophen oral liquid 160 mg/5ml</i>	Preferred	
<i>mapap oral capsule 500 mg</i>	Preferred	
<i>m-pap oral liquid 160 mg/5ml</i>	Preferred	
<i>pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>pain and fever relief kids oral liquid 160 mg/5ml</i>	Preferred	
<i>sm 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>sm arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>sm arthritis pain reliever oral tablet extended release 650 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>sm pain reliever ex st oral tablet 500 mg</i>	Preferred	
<i>sm pain reliever oral tablet 325 mg</i>	Preferred	
<i>sm rapid melts junior oral tablet dispersible 160 mg</i>	Preferred	
FEVERALL ADULTS RECTAL SUPPOSITORY 650 MG (acetaminophen)	Preferred	
FEVERALL CHILDRENS RECTAL SUPPOSITORY 120 MG (acetaminophen)	Preferred	
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG (acetaminophen)	Preferred	
FEVERALL JUNIOR STRENGTH RECTAL SUPPOSITORY 325 MG (acetaminophen)	Preferred	
MAPAP ACETAMINOPHEN EXTRA STR ORAL LIQUID 500 MG/15ML (acetaminophen)	Preferred	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG, 80 MG (acetaminophen)	Preferred	
*ANALGESICS-SEDATIVES***		
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine (Bac Oral Tablet 50-325-40 Mg)</i>	Preferred	QL (6 EA per 1 day)
*ANDROGEN BIOSYNTHESIS INHIBITORS***		
<i>abiraterone acetate oral tablet 250 mg</i>	Preferred	SP; PA; QL (4 EA per 1 day)
<i>abiraterone acetate oral tablet 500 mg</i>	Preferred	SP; PA; QL (2 EA per 1 day)
*ANDROGENS***		
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	Preferred	
<i>testosterone cypionate (Depo-Testosterone Intramuscular Solution 100 Mg/ML, 200 Mg/ML)</i>	Preferred	
*ANESTHETICS TOPICAL ORAL - COMBINATIONS***		
<i>sore throat mouth/throat lozenge 15-3.6 mg</i>	Preferred	
*ANESTHETICS TOPICAL ORAL***		
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	Preferred	
*ANTACID & SIMETHICONE***		
<i>alum & mag hydroxide-simeth oral suspension 1200-1200-120 mg/30ml</i>	Preferred	
<i>antacid & antigas oral suspension 2400-2400-240 mg/30ml</i>	Preferred	
<i>antacid maximum strength oral suspension 400-400-40 mg/5ml, 800-800-80 mg/10ml</i>	Preferred	
<i>antacid oral suspension 400-400-40 mg/10ml</i>	Preferred	
<i>antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>antacid/antigas oral suspension 400-400-40 mg/10ml</i>	Preferred	
<i>ft antacid & antigas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>gnp antacid & anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>gnp antacid & anti-gas oral tablet chewable 1000-60 mg</i>	Preferred	
<i>gnp antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>mag-al plus oral liquid 200-200-20 mg/5ml</i>	Preferred	
<i>mag-al plus xs oral liquid 400-400-40 mg/5ml</i>	Preferred	
<i>mintox maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid advanced oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid oral suspension 400-400-40 mg/10ml</i>	Preferred	
ALMACONE DOUBLE STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML (<i>alum & mag hydroxide-simeth</i>)	Preferred	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG (<i>alum & mag hydroxide-simeth</i>)	Preferred	
*ANTACID COMBINATIONS***		
<i>antacid extra strength oral tablet chewable 160-105 mg</i>	Preferred	
<i>gnp antacid extra strength oral tablet chewable 160-105 mg</i>	Preferred	
<i>heartburn relief ex st oral suspension 254-237.5 mg/5ml</i>	Preferred	
<i>mag-al oral liquid 200-200 mg/5ml</i>	Preferred	
ACID GONE ORAL SUSPENSION 95-358 MG/15ML (<i>alum hydroxide-mag carbonate</i>)	Preferred	
ACID GONE ORAL TABLET CHEWABLE 160-105 MG (<i>alum hydroxide-mag carbonate</i>)	Preferred	
*ANTACIDS - ALUMINUM SALTS***		
<i>aluminum hydroxide gel oral suspension 320 mg/5ml</i>	Preferred	
*ANTACIDS - BICARBONATE***		
<i>sodium bicarbonate oral tablet 325 mg, 650 mg</i>	Preferred	
*ANTACIDS - CALCIUM SALTS***		
<i>antacid calcium oral tablet chewable 500 mg</i>	Preferred	
<i>antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>antacid oral tablet chewable 750 mg</i>	Preferred	
<i>antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>calcium antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>calcium carbonate antacid oral suspension 1250 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>calcium carbonate antacid oral tablet 648 mg</i>	Preferred	
<i>ft antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>ft antacid regular strength oral tablet chewable 500 mg</i>	Preferred	
<i>gnp antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>gnp antacid oral tablet chewable 500 mg</i>	Preferred	
<i>gnp antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>hm antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>sm antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm calcium antacid ex st oral tablet chewable 750 mg</i>	Preferred	
<i>sm calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm smooth antacid ex st oral tablet chewable 750 mg</i>	Preferred	
<i>smooth antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
CAL-GEST ANTACID ORAL TABLET CHEWABLE 500 MG (<i>calcium carbonate antacid</i>)	Preferred	
*ANTACIDS - MAGNESIUM SALTS***		
<i>magnesium oxide oral tablet 400 mg, 420 mg</i>	Preferred	
*ANTHELMINTICS***		
<i>albendazole oral tablet 200 mg</i>	Preferred	PA (Eligible for auto-PA approval); QL (4 EA per 1 day)
<i>ivermectin oral tablet 3 mg</i>	Preferred	
*ANTIADRENERGICS - PERIPHERALLY ACTING***		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	Preferred	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
*ANTIANDROGENS***		
<i>bicalutamide oral tablet 50 mg</i>	Preferred	
*ANTIANGINALS-OTHER***		
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	Preferred	QL (2 EA per 1 day)
*ANTIANSXIETY AGENTS - MISC.***		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 5 mg</i>	Preferred	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 2 Years)
<i>hydroxyzine pamoate oral capsule 100 mg</i>	Preferred	
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	Preferred	AGE (Min 2 Years)
*ANTIARRHYTHMICS TYPE I-B***		
<i>lidocaine hcl (cardiac) pf intravenous solution 100 mg/5ml</i>	Preferred	
*ANTIARRHYTHMICS TYPE I-C***		
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	Preferred	
*ANTIARRHYTHMICS TYPE III***		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	Preferred	
<i>amiodarone hcl (Pacerone Oral Tablet 100 Mg, 200 Mg, 400 Mg)</i>	Preferred	
*ANTIBIOTIC MIXTURES TOPICAL***		
<i>double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>ft antibiotic + pain relief external cream 3.5-10000-10</i>	Preferred	
<i>ft double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>ft triple antibiotic + pain external ointment 1 %</i>	Preferred	
<i>ft triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>gnp antibiotic/pain relief external cream 3.5-10000-10</i>	Preferred	
<i>gnp triple antibiotic external ointment</i>	Preferred	
<i>gnp triple antibiotic plus external ointment 1 %</i>	Preferred	
<i>goodsense first aid antibiotic external ointment</i>	Preferred	
<i>poly bacitracin external ointment 500-10000 unit/gm</i>	Preferred	
<i>sm antibiotic plus pain relief external cream 3.5-10000-10</i>	Preferred	
<i>sm double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>sm triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>sm triple antibiotic max st external ointment 1 %</i>	Preferred	
<i>sm triple antibiotic original external ointment 3.5-400-5000</i>	Preferred	
<i>triple antibiotic external ointment , 3.5-400-5000 , 5-400-5000</i>	Preferred	
<i>triple antibiotic plus external ointment 1 %</i>	Preferred	
<i>triple antibiotic+pain relief external ointment 1 %</i>	Preferred	
*ANTIBIOTICS - TOPICAL***		
<i>bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin zinc-aloe external ointment 500 unit/gm</i>	Preferred	
<i>ft antibiotic external ointment 500 unit/gm</i>	Preferred	
<i>gentamicin sulfate external cream 0.1 %</i>	Preferred	
<i>gentamicin sulfate external ointment 0.1 %</i>	Preferred	
<i>gnp bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>sm antibiotic external ointment 500 unit/gm</i>	Preferred	
*ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.***		
<i>acidophilus lactobacillus oral capsule</i>	Preferred	
<i>acidophilus-bacillus coagulans oral tablet</i>	Preferred	
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	Preferred	
<i>ft stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>ft stomach relief oral tablet 262 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ft stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>gnp pink bismuth oral tablet 262 mg</i>	Preferred	
<i>gnp pink bismuth oral tablet chewable 262 mg</i>	Preferred	
<i>gnp pink bismuth ultra str oral suspension 525 mg/15ml</i>	Preferred	
<i>gnp stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>lactobacillus oral packet</i>	Preferred	
<i>lactobacillus oral tablet</i>	Preferred	
<i>quad-probiotic oral capsule</i>	Preferred	
<i>saccharomyces boulardii oral capsule 250 mg</i>	Preferred	
<i>sm acidophilus oral capsule 10 mg</i>	Preferred	
<i>sm stomach relief oral suspension 262 mg/15ml</i>	Preferred	
<i>sm stomach relief oral tablet 262 mg</i>	Preferred	
<i>sm stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>stomach relief extra strength oral suspension 525 mg/15ml</i>	Preferred	
<i>stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>stomach relief oral tablet 262 mg</i>	Preferred	
<i>stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>stomach relief ultra oral suspension 525 mg/15ml</i>	Preferred	
BOLSITOL ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
DERMACINRX PROBISOL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DERMACINRX PROBITRAN ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
ENVIVE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORANEX ORAL PACKET (<i>lactobacillus</i>)	Preferred	
FLORANEX ORAL TABLET (<i>lactobacillus</i>)	Preferred	
LACTEROL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
MICROFLOR 33 ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBINATE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBITROL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROMEROL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROVELLA ORAL TABLET (<i>probiotic product</i>)	Preferred	
RISA-BID PROBIOTIC ORAL TABLET (<i>probiotic product</i>)	Preferred	
RISAQUAD ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
RISAQUAD-2 ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
*ANTIDIARRHEAL/PROBIOTIC COMBINATIONS***		
<i>acidophilus/citrus pectin oral tablet</i>	Preferred	
*ANTIDOTES - CHELATING AGENTS***		
<i>deferasirox granules oral packet 180 mg, 360 mg</i>	Preferred	PA
<i>deferasirox oral packet 180 mg, 360 mg</i>	Preferred	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
*ANTIDOTES AND SPECIFIC ANTAGONISTS***		
<i>potassium iodide (antidote) oral solution 65 mg/ml</i>	Preferred	
*ANTIEMETIC COMBINATIONS***		
<i>anti-nausea oral solution 1.87-1.87-21.5</i>	Preferred	
<i>gnp anti-nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>gnp nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>goodsense nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
*ANTIESTROGENS***		
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	Preferred	
*ANTIFLATULENTS***		
<i>ft gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>ft gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>ft gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>ft gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>ft gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>gnp anti-gas oral capsule 180 mg</i>	Preferred	
<i>gnp gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>gnp gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>gnp gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>gnp infant gas relief oral suspension 20 mg/0.3ml</i>	Preferred	
<i>goodsense gas relief extra st oral capsule 125 mg</i>	Preferred	
<i>simethicone drops infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>simethicone oral suspension 40 mg/0.6ml</i>	Preferred	
<i>simethicone oral tablet chewable 80 mg</i>	Preferred	
<i>simethicone ultra strength oral capsule 180 mg</i>	Preferred	
<i>sm gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>sm gas relief infants drops oral suspension 40 mg/0.6ml</i>	Preferred	
<i>sm gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>sm gas relief oral capsule 180 mg</i>	Preferred	
<i>sm gas relief oral tablet chewable 125 mg, 80 mg</i>	Preferred	
*ANTIHISTAMINE HYPNOTIC COMBINATIONS***		
<i>acetaminophen pm oral tablet 500-25 mg</i>	Preferred	
<i>ft pain reliever pm extra str oral tablet 25-500 mg</i>	Preferred	
<i>gnp pain relief es night time oral tablet 25-500 mg</i>	Preferred	

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<i>gnp pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>goodsense pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>sm headache relief pm oral tablet 500-38 mg</i>	Preferred	
*ANTIHISTAMINE HYPNOTICS***		
<i>ft nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	Preferred	
<i>nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	Preferred	
<i>sleep tabs oral tablet 25 mg</i>	Preferred	
*ANTIHISTAMINES - ALKYLAMINES***		
<i>aller-chlor oral tablet 4 mg</i>	Preferred	
<i>allergy oral tablet 4 mg</i>	Preferred	
<i>allergy relief oral tablet 4 mg</i>	Preferred	
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	Preferred	
<i>ed chlorped jr oral syrup 2 mg/5ml</i>	Preferred	
<i>ft allergy relief oral tablet 4 mg</i>	Preferred	
<i>gnp allergy relief oral tablet 4 mg</i>	Preferred	
<i>triprolidine hcl oral liquid 0.625 mg/ml, 0.938 mg/ml</i>	Preferred	
ALA-HIST IR ORAL TABLET 2 MG (<i>dexbrompheniramine maleate</i>)	Preferred	
HISTEX ORAL SYRUP 2.5 MG/5ML (<i>triprolidine hcl</i>)	Preferred	
HISTEX PD ORAL LIQUID 0.938 MG/ML (<i>triprolidine hcl</i>)	Preferred	
*ANTIHISTAMINES - ETHANOLAMINES***		
<i>allergy oral capsule 25 mg</i>	Preferred	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>allergy relief oral capsule 25 mg</i>	Preferred	
<i>allergy relief oral tablet 25 mg</i>	Preferred	
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>carbinoxamine maleate oral tablet 4 mg</i>	Preferred	AGE (Min 2 Years)
<i>clemastine fumarate oral tablet 2.68 mg</i>	Preferred	AGE (Min 2 Years)
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Preferred	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	Preferred	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	Preferred	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml, 25 mg/10ml</i>	Preferred	
<i>diphenhydramine hcl oral tablet 25 mg</i>	Preferred	
<i>ft allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>ft allergy relief oral capsule 25 mg</i>	Preferred	
<i>ft allergy relief oral tablet 25 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp allergy oral capsule 25 mg</i>	Preferred	
<i>gnp allergy oral tablet 25 mg</i>	Preferred	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	Preferred	
<i>gnp allergy relief oral capsule 25 mg</i>	Preferred	
<i>gnp allergy relief oral tablet 25 mg</i>	Preferred	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	Preferred	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	Preferred	
<i>m-dryl oral liquid 12.5 mg/5ml</i>	Preferred	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>sm allergy relief oral tablet 25 mg</i>	Preferred	
BANOPHEN ORAL CAPSULE 25 MG, 50 MG (<i>diphenhydramine hcl</i>)	Preferred	
BANOPHEN ORAL TABLET 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
*ANTIHISTAMINES - PIPERIDINES***		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>cyproheptadine hcl oral tablet 4 mg</i>	Preferred	AGE (Min 2 Years)
*ANTIHISTAMINE-TOPICAL COMBINATIONS***		
<i>anti-itch external cream 2-0.1 %</i>	Preferred	
<i>diphenhydramine-zinc acetate external cream 2-0.1 %</i>	Preferred	
<i>ft anti-itch extra strength external cream 2-0.1 %</i>	Preferred	
<i>gnp anti-itch external cream 2-0.1 %</i>	Preferred	
<i>itch relief extra strength external cream 2-0.1 %</i>	Preferred	
<i>sm anti-itch extra strength external cream 2-0.1 %</i>	Preferred	
BANOPHEN EXTERNAL CREAM 2-0.1 % (<i>diphenhydramine-zinc acetate</i>)	Preferred	
*ANTI-INFECTIVE AGENTS - MISC.***		
<i>trimethoprim oral tablet 100 mg</i>	Preferred	
*ANTI-INFECTIVE MISC. - COMBINATIONS***		
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml, 800-160 mg/20ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sulfamethoxazole-trimethoprim (Sulfatrim Pediatric Oral Suspension 200-40 Mg/5MI)</i>	Preferred	90-day fill allowed after two 1-month fills
*ANTIMALARIAL COMBINATIONS***		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	Preferred	
*ANTIMALARIALS***		
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	Preferred	PA
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>mefloquine hcl oral tablet 250 mg</i>	Preferred	
<i>quinine sulfate oral capsule 324 mg</i>	Preferred	QL (42 EA per 365 days)
SOVUNA ORAL TABLET 200 MG (<i>hydroxychloroquine sulfate</i>)	Preferred	
*ANTIMANIC AGENTS***		
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>lithium carbonate oral tablet 300 mg</i>	Preferred	90-day fill allowed after two 1-month fills
*ANTIMETABOLITES***		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	Preferred	SP; PA
<i>mercaptopurine oral tablet 50 mg</i>	Preferred	
*ANTIMYASTHENIC/CHOLINERGIC AGENTS***		
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	Preferred	
<i>pyridostigmine bromide oral tablet 60 mg</i>	Preferred	
*ANTIMYCOBACTERIAL AGENTS***		
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	Preferred	
<i>isoniazid oral syrup 50 mg/5ml</i>	Preferred	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	Preferred	
<i>rifabutin oral capsule 150 mg</i>	Preferred	PA
<i>rifampin oral capsule 150 mg, 300 mg</i>	Preferred	
*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS***		
<i>imatinib mesylate oral tablet 100 mg</i>	Preferred	SP; PA; QL (8 EA per 1 day)
<i>imatinib mesylate oral tablet 400 mg</i>	Preferred	SP; PA; QL (2 EA per 1 day)
*ANTINEOPLASTIC - MULTIKINASE INHIBITORS***		
<i>sunitinib malate oral capsule 12.5 mg</i>	Preferred	SP; PA; QL (7 EA per 1 day)
<i>sunitinib malate oral capsule 25 mg</i>	Preferred	SP; PA; QL (3 EA per 1 day)
<i>sunitinib malate oral capsule 37.5 mg, 50 mg</i>	Preferred	SP; PA; QL (1 EA per 1 day)
*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL***		
<i>fluorouracil external cream 5 %</i>	Preferred	
<i>fluorouracil external solution 5 %</i>	Preferred	
*ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S***		
<i>diclofenac sodium external gel 3 %</i>	Preferred	PA; QL (3.334 GM per 1 day)
*ANTINEOPLASTICS MISC.***		
<i>hydroxyurea oral capsule 500 mg</i>	Preferred	
*ANTIPARKINSON ANTICHOLINERGICS***		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	Preferred	

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<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	Preferred	
*ANTIPARKINSON DOPAMINERGICS***		
<i>amantadine hcl oral capsule 100 mg</i>	Preferred	
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS***		
<i>selegiline hcl oral capsule 5 mg</i>	Preferred	
<i>selegiline hcl oral tablet 5 mg</i>	Preferred	
*ANTIPERISTALTIC AGENTS***		
<i>anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	Preferred	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	Preferred	
<i>ft anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>ft anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>ft anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>gnp anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>gnp anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>gnp loperamide hcl oral solution 1 mg/7.5ml</i>	Preferred	
<i>goodsense anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>hm anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral capsule 2 mg</i>	Preferred	
<i>loperamide hcl oral solution 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral tablet 2 mg</i>	Preferred	
<i>sm anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>sm anti-diarrheal oral solution 1 mg/7.5ml</i>	Preferred	
<i>sm anti-diarrheal oral tablet 2 mg</i>	Preferred	
*ANTIPROTOZOAL AGENTS***		
<i>atovaquone oral suspension 750 mg/5ml</i>	Preferred	PA
*ANTISEBORRHEIC PRODUCTS***		
<i>anti-dandruff external shampoo 1 %</i>	Preferred	
<i>dandruff shampoo external lotion 1 %</i>	Preferred	
<i>selenium sulfide external lotion 2.5 %</i>	Preferred	
<i>selenium sulfide external shampoo 2.25 %</i>	Preferred	
*ANTISEPTICS - MOUTH/THROAT***		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	Preferred	
<i>gnp sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
<i>phenaseptic mouth/throat liquid 1.4 %</i>	Preferred	
<i>sm sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
<i>sore throat mouth/throat liquid 1.4 %</i>	Preferred	
<i>sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	

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*ANTISPASMODICS***		
<i>dicyclomine hcl oral capsule 10 mg</i>	Preferred	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	Preferred	
<i>dicyclomine hcl oral tablet 20 mg</i>	Preferred	
*ANTITHYROID AGENTS***		
<i>methimazole oral tablet 10 mg, 5 mg</i>	Preferred	
<i>propylthiouracil oral tablet 50 mg</i>	Preferred	
*ANTITUSSIVE - NONNARCOTIC***		
<i>benzonatate oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>benzonatate oral capsule 200 mg</i>	Preferred	QL (3 EA per 1 day)
<i>cough dm childrens oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>dextromethorphan hbr oral capsule 15 mg</i>	Preferred	
<i>dextromethorphan polistirex er oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>ft 12 hour cough relief oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>gnp cough dm er oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>gnp tussin cough long acting oral syrup 15 mg/5ml</i>	Preferred	
<i>goodsense cough dm childrens oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>goodsense cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>hm cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>sm cough relief oral syrup 15 mg/5ml</i>	Preferred	
*ANTITUSSIVE-ANTI-HISTAMINE-ANALGESIC***		
<i>all-nite cold & flu nighttime oral liquid 30-12.5-650 mg/30ml</i>	Preferred	
<i>cold & flu nighttime relief oral capsule 15-6.25-325 mg</i>	Preferred	
<i>cold & flu relief nighttime oral capsule 15-6.25-325 mg</i>	Preferred	
<i>ft nighttime cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>gnp night time cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>gnp night time cold-flu oral capsule 15-6.25-325 mg</i>	Preferred	
<i>goodsense nighttime cold & flu oral capsule 15-6.25-325 mg</i>	Preferred	
<i>nighttime cold/flu relief oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>sm cough/sore throat nighttime oral liquid 30-12.5-1000 mg/30ml</i>	Preferred	
<i>sm nite time cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
*ANTITUSSIVE-DECONGESTANT-ANALGESIC***		
<i>cold & flu relief daytime oral capsule 10-5-325 mg</i>	Preferred	
<i>cold/flu daytime relief oral capsule 10-5-325 mg</i>	Preferred	

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<i>daytime cold & flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>flu/severe cold & cough day oral packet 20-10-650 mg</i>	Preferred	
<i>ft daytime cold & flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>gnp cold max daytime oral tablet 10-5-325 mg</i>	Preferred	
<i>gnp day time cold/flu oral capsule 10-5-325 mg</i>	Preferred	
<i>goodsense cold & flu oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>goodsense day time cold & flu oral capsule 10-5-325 mg</i>	Preferred	
<i>sm day time cold & flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
MAPAP COLD FORMULA MULTI-SYMPT ORAL TABLET 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
*ANTITUSSIVE-EXPECTORANT - DECONGEST-ANALGESIC***		
<i>ft cold & flu daytime severe oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>ft cold & flu daytime severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp cold/flu severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>goodsense day time cold & flu oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>severe cold & flu oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm cold & flu severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm daytime severe cold & flu oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>tussin cf severe multi-symptom oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
*ANTITUSSIVE-EXPECTORANT***		
<i>chest congestion relief dm oral syrup 10-100 mg/5ml</i>	Preferred	
<i>chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>dextromethorphan-guaifenesin oral liquid 10-100 mg/5ml, 5-100 mg/5ml</i>	Preferred	
<i>dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml, 20-200 mg/10ml</i>	Preferred	
<i>dm-guaifenesin er oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>ft chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>ft mucus relief dm oral tablet extended release 12 hour 1200-60 mg, 30-600 mg</i>	Preferred	
<i>ft tussin dm max adult oral liquid 20-400 mg/20ml</i>	Preferred	
<i>gnp mucus dm max strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>gnp mucus relief dm oral tablet 20-400 mg</i>	Preferred	
<i>gnp tab tussin dm oral tablet 20-400 mg</i>	Preferred	
<i>gnp tussin dm cough oral liquid 100-10 mg/5ml</i>	Preferred	
<i>gnp tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>goodsense mucus dm oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>goodsense tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>guaifenesin-dm oral syrup 100-10 mg/5ml</i>	Preferred	
<i>mucus relief cough childrens oral liquid 5-100 mg/5ml</i>	Preferred	
<i>mucus relief dm cough oral tablet 20-400 mg</i>	Preferred	
<i>mucus relief dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>mucus relief dm max oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>mucus relief dm oral liquid 20-400 mg/20ml</i>	Preferred	
<i>mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	
<i>mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>sm chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>sm tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>sm tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	
<i>tusnel diabetic oral liquid 10-100 mg/5ml</i>	Preferred	
<i>tussin dm cough + chest oral liquid 10-100 mg/5ml, 20-400 mg/20ml</i>	Preferred	
<i>tussin dm oral liquid 100-10 mg/5ml</i>	Preferred	
<i>tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	
*ANTITUSSIVE-EXPECTORANTS-DECONGESTANT***		
<i>capmist dm oral tablet 60-15-400 mg</i>	Preferred	
<i>ft tussin cf adult oral liquid 10-20-200 mg/10ml</i>	Preferred	
<i>gnp tussin cf cough & cold oral syrup 5-10-100 mg/5ml</i>	Preferred	
<i>goodsense mucus relief child oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>goodsense tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>multi-symptom cold childrens oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>robafen cf multi-symptom cold oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>sm mucus relief cold childrens oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>sm severe congestion & cough oral liquid 10-20-400 mg/20ml</i>	Preferred	
<i>sm tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>tussin multi-symptom cold cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
TUSNEL ORAL LIQUID 30-15-200 MG/5ML (<i>pseudoephedrine-dm-gg</i>)	Preferred	
TUSNEL PEDIATRIC ORAL LIQUID 15-5-50 MG/5ML (<i>pseudoephedrine-dm-gg</i>)	Preferred	
*ANTIVIRAL COMBINATIONS***		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	Preferred	Max 5-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	Preferred	Max 5-day supply per 1 Fill
*ANTIVIRAL MONOCLONAL ANTIBODIES***		
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML (<i>palivizumab</i>)	Preferred	SP; PA
*APPLICATORS,COTTON BALLS,ETC***		
<i>alcohol pads pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>alcohol prep pad , 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>alcohol prep pads pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>alcohol swabs pad , 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>alcoh-wipe sheet</i>	Preferred	
<i>aum alcohol prep pads pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs alcohol prep pads pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs prep pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>easy comfort alcohol pads pad</i>	Preferred	Max 100-day supply per 1 Fill
<i>eql alcohol swabs pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>essentra wipes 9x9" sheet 70 %</i>	Preferred	
<i>global alcohol prep ease pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>gnp alcohol swabs pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>h-e-b incontrol alcohol pad</i>	Preferred	Max 100-day supply per 1 Fill
<i>hm sterile alcohol prep pad</i>	Preferred	Max 100-day supply per 1 Fill
<i>meijer alcohol swabs pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>pro comfort alcohol pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>pure comfort alcohol prep pad</i>	Preferred	Max 100-day supply per 1 Fill
<i>qc alcohol swabs pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>ra alcohol swabs pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>reality swabs pad</i>	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>saps care alcohol prep pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>saps health alcohol prep pad , 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>saps health care alcohol prep pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>sb alcohol prep pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>sm alcohol prep pad , 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort alcohol prep pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>true comfort alcohol prep pads pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>true comfort pro alcohol prep pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>ultilet alcohol swabs pad</i>	Preferred	Max 100-day supply per 1 Fill
<i>ultra-care alcohol prep pads pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
<i>zevrx sterile alcohol prep pad pad 70 %</i>	Preferred	Max 100-day supply per 1 Fill
ADVOCATE ALCOHOL PREP PADS PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
ALCOH-GLOVE CONTOURED WIPE PAD (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
ALCOHOL SWABSTICK PAD (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
BD SWAB SINGLE USE REGULAR PAD (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
CURITY ALCOHOL PREPS PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
DROPSAFE ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
FIFTY50 ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
PHARMACIST CHOICE ALCOHOL PAD (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
RELION ALCOHOL SWABS PAD , 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
ULTICARE ALCOHOL SWABS PAD , 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
WEBCOL ALCOHOL PREP LARGE PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
WEBCOL ALCOHOL PREP MEDIUM PAD 70 % (<i>alcohol swabs</i>)	Preferred	Max 100-day supply per 1 Fill
*AROMATASE INHIBITORS***		
<i>anastrozole oral tablet 1 mg</i>	Preferred	
<i>letrozole oral tablet 2.5 mg</i>	Preferred	
*ARTIFICIAL TEAR AND LUBRICANT COMBINATIONS***		
<i>artificial tears ophthalmic solution 0.5-0.6 %</i>	Preferred	
<i>dry eye relief drops ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>ft lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>gnp artificial tears ophthalmic solution 5-6 mg/ml</i>	Preferred	
<i>gnp eye drops long lasting ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>gnp eye drops ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>gnp nighttime relief lub eye ophthalmic ointment 57.3-42.5 %</i>	Preferred	
<i>lubricant eye drops (pf) ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>lubricant eye nighttime ophthalmic ointment</i>	Preferred	
<i>lubricating eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>lubrifresh p.m. ophthalmic ointment</i>	Preferred	
<i>sm dry eye relief ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>sm lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>sm lubricating tears ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>ultra lubricating eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>ultra lubricating eye drops pf ophthalmic solution 0.4-0.3 %</i>	Preferred	
BION TEARS PF OPHTHALMIC SOLUTION 0.1-0.3 % (<i>dextran 70-hypromellose</i>)	Preferred	
GENTEAL TEARS NIGHT-TIME OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
GENTEAL TEARS SEVERE DAY/NIGHT OPHTHALMIC GEL 0.4-0.3 % (<i>polyethyl glycol-propyl glycol</i>)	Preferred	
REFRESH DIGITAL OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH DIGITAL PF OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH LACRI-LUBE OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
REFRESH OPHTHALMIC SOLUTION 1.4-0.6 % (<i>polyvinyl alcohol-povidone</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
REFRESH OPTIVE ADVANCED OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH OPTIVE ADVANCED PF OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH OPTIVE MEGA-3 OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH OPTIVE OPHTHALMIC GEL 1-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
REFRESH OPTIVE PF OPHTHALMIC SOLUTION 0.5-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
REFRESH P.M. OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
REFRESH RELIEVA PF OPHTHALMIC SOLUTION 0.5-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
REFRESH TEARS PF OPHTHALMIC SOLUTION 0.5-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
SYSTANE NIGHTTIME OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
SYSTANE OPHTHALMIC GEL 0.4-0.3 % (<i>polyethyl glycol-propyl glycol</i>)	Preferred	
*ARTIFICIAL TEAR SOLUTIONS***		
<i>artificial tears ophthalmic solution</i>	Preferred	
<i>sm artificial tears ophthalmic solution</i>	Preferred	
GENTEAL TEARS OPHTHALMIC SOLUTION 0.1-0.2-0.3 % (<i>artificial tear solution</i>)	Preferred	
SYSTANE CONTACTS OPHTHALMIC SOLUTION (<i>artificial tear solution</i>)	Preferred	
*ARTIFICIAL TEARS AND LUBRICANTS***		
<i>carboxymethylcellulose sodium ophthalmic solution 0.5 %</i>	Preferred	
<i>ft lubricant eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>gnp lubricant eye drops (pf) ophthalmic solution 0.5 %</i>	Preferred	
<i>gnp lubricating plus eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>goodsense lubricating eye drop ophthalmic solution 0.5 %</i>	Preferred	
<i>lubricant eye drops ophthalmic solution 0.6 %</i>	Preferred	
<i>lubricant eye drops pf ophthalmic solution 0.5 %</i>	Preferred	
<i>polyvinyl alcohol ophthalmic solution 1.4 %</i>	Preferred	
<i>sentia ophthalmic solution 0.6 %</i>	Preferred	
<i>sm lubricating plus ophthalmic solution 0.5 %</i>	Preferred	
<i>ventiva tears ophthalmic solution 0.5 %</i>	Preferred	
ALCON TEARS OPHTHALMIC SOLUTION 0.5 % (<i>hypromellose</i>)	Preferred	
GENTEAL SEVERE OPHTHALMIC GEL 0.3 % (<i>hypromellose</i>)	Preferred	
REFRESH CELLUVISC OPHTHALMIC GEL 1 % (<i>carboxymethylcellulose sodium</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
*ASTRINGENTS***		
<i>diaper rash external ointment 40 %</i>	Preferred	
<i>gnp calamine phenolated external lotion</i>	Preferred	
<i>gnp zinc oxide external ointment 20 %</i>	Preferred	
<i>sm calamine phenolated external lotion</i>	Preferred	
<i>sm hygienic cleansing external pad 50 %</i>	Preferred	
<i>zinc oxide external ointment 20 %</i>	Preferred	
*B-COMPLEX VITAMINS***		
<i>b-complex/b-12 oral tablet</i>	Preferred	
<i>vitamin b complex oral capsule</i>	Preferred	
<i>vitamin b complex w/b-12 oral tablet</i>	Preferred	
*B-COMPLEX W/ C & FOLIC ACID***		
<i>folbee plus oral tablet</i>	Preferred	
<i>folika-bc oral tablet 1 mg</i>	Preferred	
<i>tm-vite rx oral tablet 1 mg</i>	Preferred	
<i>triphrocaps oral capsule 1 mg</i>	Preferred	
<i>wescaps oral capsule 1 mg</i>	Preferred	
DIALYVITE 800 ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	Preferred	
<i>b complex-c-folic acid</i> (Dialyvitte Oral Tablet)	Preferred	
<i>b complex-c-folic acid</i> (Nephronex Oral Tablet)	Preferred	
NEPHRO-VITE ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	Preferred	
*B-COMPLEX W/ C***		
<i>sm super b complex/c oral tablet</i>	Preferred	
*B-COMPLEX W/ C-ZN & FOLIC ACID***		
DIALYVITE 800/ZINC ORAL TABLET 0.8 MG (<i>b complex-c-zn-folic acid</i>)	Preferred	
DIALYVITE 800-ZINC 15 ORAL TABLET 0.8 MG (<i>b complex-c-zn-folic acid</i>)	Preferred	
*B-COMPLEX W/ MINERALS***		
ELDERTONIC ORAL LIQUID (<i>b complex-minerals</i>)	Preferred	
*BENZODIAZEPINES***		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam oral tablet 2 mg</i>	Preferred	QL (5 EA per 1 day)
<i>chlordiazepoxide hcl oral capsule 10 mg</i>	Preferred	QL (30 EA per 1 day)
<i>chlordiazepoxide hcl oral capsule 25 mg</i>	Preferred	QL (12 EA per 1 day)
<i>chlordiazepoxide hcl oral capsule 5 mg</i>	Preferred	QL (4 EA per 1 day)
<i>diazepam oral concentrate 5 mg/ml</i>	Preferred	
<i>diazepam oral solution 5 mg/5ml</i>	Preferred	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	Preferred	
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	Preferred	QL (3 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>lorazepam oral tablet 2 mg</i>	Preferred	QL (5 EA per 1 day)
<i>diazepam (Diazepam Intensol Oral Concentrate 5 Mg/MI)</i>	Preferred	
*BETA ADRENERGICS***		
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	Preferred	
*BIPHASIC CONTRACEPTIVES - ORAL***		
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	Preferred	Max 365-day supply per 1 Fill
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))</i>	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))</i>	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))</i>	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))</i>	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))</i>	Preferred	Max 365-day supply per 1 Fill
*BOWEL EVACUANT COMBINATIONS***		
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	Preferred	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	Preferred	
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm</i>	Preferred	
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	Preferred	
<i>GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (peg 3350-kcl-nabcb-nacl-nasulf)</i>	Preferred	
<i>peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)</i>	Preferred	
<i>peg 3350-kcl-na bicarb-nacl (Gavilyte-N With Flavor Pack Oral Solution Reconstituted 420 Gm)</i>	Preferred	
*BULK LAXATIVES***		
<i>fiber laxative + calcium oral tablet 625 mg</i>	Preferred	
<i>fiber oral tablet 625 mg</i>	Preferred	
<i>fiber-lax oral tablet 625 mg</i>	Preferred	
<i>ft fiber laxative oral tablet 500 mg, 625 mg</i>	Preferred	
<i>gnp fiber oral powder 43 %</i>	Preferred	
<i>gnp fiber therapy oral tablet 500 mg</i>	Preferred	
<i>gnp fiber-caps oral tablet 625 mg</i>	Preferred	
<i>gnp natural fiber oral capsule 0.52 gm</i>	Preferred	
<i>gnp natural fiber oral powder 28.3 %</i>	Preferred	
<i>sm fiber laxative oral tablet 500 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm fiber oral powder 28.3 %, 43 %, 58.6 %</i>	Preferred	
<i>sm fiber oral tablet 625 mg</i>	Preferred	
SOLUBLE FIBER THERAPY ORAL POWDER (<i>methylcellulose (laxative)</i>)	Preferred	
*BURN PRODUCTS***		
<i>silver sulfadiazine external cream 1 %</i>	Preferred	
<i>silver sulfadiazine (Ssd External Cream 1 %)</i>	Preferred	
*CALCIMIMETIC AGENTS***		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg</i>	Preferred	PA; QL (2 EA per 1 day)
*CALCIUM COMBINATIONS***		
<i>calcium + vitamin d3 oral tablet 500-5 mg-mcg</i>	Preferred	
<i>calcium-vitamin d3 oral tablet 250-3.125 mg-mcg</i>	Preferred	
<i>citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>gnp calcium citrate +d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>oyster shell calcium w/d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium/vit d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>risacal-d oral tablet 105-81-120 mg-mg-unit</i>	Preferred	
<i>sm calcium 500/vitamin d3 oral tablet 500-10 mg-mcg</i>	Preferred	
<i>sm calcium 600/vitamin d oral tablet 600-10 mg-mcg</i>	Preferred	
<i>sm calcium citrate-vit d oral tablet 315-5 mg-mcg</i>	Preferred	
<i>sm calcium-magnesium-zinc oral tablet 333-133-5 mg</i>	Preferred	
<i>sm oyster shell calcium/vit d oral tablet 500-10 mg-mcg</i>	Preferred	
<i>sm oyster shell calcium/vit d3 oral tablet 500-10 mg-mcg</i>	Preferred	
<i>ultra calcium + vitamin d3 oral tablet 600-10 mg-mcg</i>	Preferred	
MAGNEBIND 300 ORAL TABLET 250-300 MG (<i>calcium carb-magnesium carb</i>)	Preferred	
OS-CAL CALCIUM + D3 ORAL TABLET 500-5 MG-MCG (<i>calcium carb-cholecalciferol</i>)	Preferred	
OS-CAL EXTRA D3 ORAL TABLET 500-15 MG-MCG (<i>calcium carb-cholecalciferol</i>)	Preferred	
OS-CAL ORAL TABLET CHEWABLE 500-15 MG-MCG (<i>calcium carb-cholecalciferol</i>)	Preferred	
OYSCO 500+D ORAL TABLET 500-5 MG-MCG (<i>calcium carb-cholecalciferol</i>)	Preferred	
*CALCIUM***		
<i>gnp calcium oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>oyster shell calcium oral tablet 500 mg</i>	Preferred	
<i>true oyster shell calcium oral tablet 1250 (500 ca) mg</i>	Preferred	
SM CORAL CALCIUM ORAL TABLET 1000 (390 CA) MG (<i>coral calcium</i>)	Preferred	
*CARBOHYDRATES***		
<i>dextrose intravenous solution 5 %</i>	Preferred	

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*CARBONIC ANHYDRASE INHIBITORS***		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	Preferred	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	Preferred	
*CARDIAC GLYCOSIDES***		
<i>digoxin oral solution 0.05 mg/ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	Preferred	90-day fill allowed after two 1-month fills
*CEPHALOSPORINS - 1ST GENERATION***		
<i>cefadroxil oral capsule 500 mg</i>	Preferred	
<i>cefadroxil oral suspension reconstituted 500 mg/5ml</i>	Preferred	
<i>cefadroxil oral tablet 1 gm</i>	Preferred	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	Preferred	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
*CHELATING AGENTS***		
<i>penicillamine oral tablet 250 mg</i>	Preferred	PA; QL (4 EA per 1 day)
*CHLORINE ANTISEPTICS***		
<i>H-CHLOR 12 EXTERNAL SOLUTION 0.125 % (sodium hypochlorite)</i>	Preferred	
<i>HYSEPT 25 EXTERNAL SOLUTION 0.25 % (sodium hypochlorite)</i>	Preferred	
*CITRATES***		
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	Preferred	
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	Preferred	
<i>sod citrate-citric acid oral solution 1.5-1 gm/15ml, 3-2 gm/30ml, 500-334 mg/5ml</i>	Preferred	
*COBALAMINS***		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	Preferred	
<i>sm vitamin b-12 oral tablet 100 mcg, 500 mcg</i>	Preferred	
<i>true vitamin b12 oral tablet 1000 mcg, 500 mcg</i>	Preferred	
<i>vitamin b-12 oral tablet 1000 mcg, 250 mcg</i>	Preferred	
<i>cyanocobalamin (Dodex Injection Solution 1000 Mcg/MI)</i>	Preferred	
*COMBINATION CONTRACEPTIVES - ORAL***		
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	Preferred	Max 365-day supply per 1 Fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	Preferred	Max 365-day supply per 1 Fill
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad (Altavera Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad (Aviane Oral Tablet 0.1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad (Ayuna Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol (Balziva Oral Tablet 0.4-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Delyla Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Gemmily Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estradiol-fe</i> (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Ocella Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin ace-eth estrad-fe</i> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
<i>norgestrel-ethinyl estradiol</i> (Turqoz Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	Preferred	Max 365-day supply per 1 Fill
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
<i>levonorgestrel-ethinyl estrad</i> (Vienna Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
*COMBINATION CONTRACEPTIVES - TRANSDERMAL***		
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per 1 Fill
<i>norelgestromin-eth estradiol</i> (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per 1 Fill
<i>norelgestromin-eth estradiol</i> (Zafemy Transdermal Patch Weekly 150-35 Mcg/24Hr)	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per 1 Fill
*COMBINATION CONTRACEPTIVES - VAGINAL***		
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
<i>etonogestrel-ethinyl estradiol</i> (Enilloring Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
*CONDOMS - MALE***		
<i>aimsco lubricated</i>	Preferred	
<i>kimono</i>	Preferred	
<i>kimono micro thin</i>	Preferred	
<i>kimono micro thin plus</i>	Preferred	
<i>kimono plus</i>	Preferred	
<i>kimono ps</i>	Preferred	
<i>kimono ps plus</i>	Preferred	
<i>kimono sensation</i>	Preferred	
<i>kimono sensation plus</i>	Preferred	
<i>maxx</i>	Preferred	
<i>maxx plus</i>	Preferred	
<i>true cover device</i>	Preferred	
DUREX EXTRA SENSITIVE THIN (<i>condoms latex lubricated</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
DUREX EXTRA SENSITIVE THIN DEVICE (<i>condoms latex lubricated</i>)	Preferred	
DUREX REALFEEL DEVICE (<i>condoms non-latex lubricated</i>)	Preferred	
DUREX TROPICAL (<i>condoms latex lubricated</i>)	Preferred	
FANTASY LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
FANTASY LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	Preferred	
KAMELEON LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
KIMONO COLORS DEVICE (<i>condoms latex lubricated</i>)	Preferred	
KIMONO MAXX-LARGE FLARE (<i>condoms latex lubricated</i>)	Preferred	
KIMONO SPECIAL DEVICE (<i>condoms latex lubricated</i>)	Preferred	
REALITY LATEX CONDOMS (<i>condoms latex lubricated</i>)	Preferred	
REALITY LATEX/ULTRA TEXTURED DEVICE (<i>condoms latex lubricated</i>)	Preferred	
REALITY LATEX/ULTRA THIN DEVICE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX COLOR CONDOMS + LUBE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUB/RIBBED/STUDDDED (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUB/SPERMICIDE EX ST (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUB/SPERMICIDE XL (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED EX LARGE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED EXTRA ST (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX NATURAL CONDOMS + LUBE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	Preferred	
TRUSTEX RIA LUB/SPERMICIDE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX RIA LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX RIA NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	Preferred	
TRUSTEX-NONOXYNOL-9/RIB/STUD (<i>condoms latex lubricated</i>)	Preferred	
*CORTICOSTEROIDS - TOPICAL***		
<i>hydrocortisone external ointment 0.5 %</i>	Preferred	
<i>sm hydrocortisone external ointment 0.5 %</i>	Preferred	
AQUANIL HC EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
*CYCLOPLEGIC MYDRIATICS***		
<i>atropine sulfate ophthalmic solution 1 %</i>	Preferred	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>tropicamide ophthalmic solution 1 %</i>	Preferred	
*CYCLOSPORINE ANALOGS***		
<i>cyclosporine modified oral capsule 100 mg, 25 mg</i>	Preferred	
<i>cyclosporine modified oral solution 100 mg/ml</i>	Preferred	
<i>cyclosporine modified (Gengraf Oral Capsule 100 Mg, 25 Mg)</i>	Preferred	
<i>cyclosporine modified (Gengraf Oral Solution 100 Mg/MI)</i>	Preferred	
*DECONGESTANT & ANTIHISTAMINE***		
<i>nohist-lq oral liquid 4-10 mg/5ml</i>	Preferred	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	Preferred	AGE (Min 6 Years)
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	Preferred	AGE (Min 6 Years)
<i>rynex pe oral elixir 1-2.5 mg/5ml</i>	Preferred	
<i>rynex pse oral liquid 1-15 mg/5ml</i>	Preferred	
<i>sm cold & allergy childrens oral elixir 1-15 mg/5ml</i>	Preferred	
<i>sm cold & allergy pe oral tablet 4-10 mg</i>	Preferred	
<i>sm sinus & allergy max st oral tablet 4-60 mg</i>	Preferred	
<i>APRODINE ORAL TABLET 2.5-60 MG (triprolidine-pseudoephedrine)</i>	Preferred	
<i>CONEX COLD/ALLERGY ORAL SOLUTION 1-30 MG/5ML (dexbrompheniramine-pseudoeph)</i>	Preferred	
<i>CONEX COLD/ALLERGY ORAL TABLET 2-60 MG (dexbrompheniramine-pseudoeph)</i>	Preferred	
<i>CONEX COLD/ALLERGY PEDIATRIC ORAL SOLUTION 1-30 MG/5ML (dexbrompheniramine-pseudoeph)</i>	Preferred	
<i>ED A-HIST ORAL LIQUID 4-10 MG/5ML (chlorpheniramine-phenylephrine)</i>	Preferred	
<i>ED A-HIST ORAL TABLET 4-10 MG (chlorpheniramine-phenylephrine)</i>	Preferred	
<i>LOHIST-D ORAL LIQUID 2-30 MG/5ML (chlorpheniramine-pseudoeph)</i>	Preferred	
<i>SUDOGEST SINUS/ALLERGY ORAL TABLET 4-60 MG (chlorpheniramine-pseudoeph)</i>	Preferred	
*DECONGESTANT W/ EXPECTORANT***		
<i>ft mucus relief d 12 hour oral tablet extended release 12 hour 60-600 mg</i>	Preferred	
<i>mucus d oral tablet extended release 12 hour 120-1200 mg</i>	Preferred	
<i>mucus relief d oral tablet extended release 12 hour 120-1200 mg, 60-600 mg</i>	Preferred	
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 120-1200 mg, 60-600 mg</i>	Preferred	
*DECONGESTANT-ANALGESIC***		
<i>cold & sinus oral tablet 30-200 mg</i>	Preferred	
<i>gnp sinus pressure/pain oral tablet 5-325 mg</i>	Preferred	
<i>gnp sinus/headache oral tablet 5-325 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>hm cold & sinus relief oral tablet 30-200 mg</i>	Preferred	
<i>sinus + headache oral tablet 5-325 mg</i>	Preferred	
<i>sinus congestion/pain oral tablet 5-325 mg</i>	Preferred	
<i>sinus pressure + pain oral tablet 5-325 mg</i>	Preferred	
<i>sm cold & sinus relief oral tablet 30-200 mg</i>	Preferred	
*DECONGESTANT-ANALGESIC-EXPECTORANT***		
<i>ft sinus severe oral tablet 5-325-200 mg</i>	Preferred	
<i>gnp cold/head congestion oral tablet 5-325-200 mg</i>	Preferred	
<i>gnp mucus relf sinus con/pain oral tablet 5-325-200 mg</i>	Preferred	
<i>gnp sinus severe daytime oral tablet 5-325-200 mg</i>	Preferred	
<i>head congestion/mucus oral tablet 5-325-200 mg</i>	Preferred	
<i>sinus relief congestion-pain oral tablet 5-325-200 mg</i>	Preferred	
<i>sm sinus severe for adults oral tablet 5-325-200 mg</i>	Preferred	
*DECONGESTANT-ANTIHISTAMINE-ANALGESIC***		
<i>allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>ft allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>gnp allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>sm flu relief therapy night oral liquid 12.5-5-325 mg/15ml</i>	Preferred	
*DIABETIC OTHER - COMBINATIONS***		
<i>sm glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
*DIABETIC OTHER***		
<i>sm glucose oral tablet chewable 4 gm</i>	Preferred	
GLUTOSE 15 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
GLUTOSE 45 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
GLUTOSE 5 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
INSTA-GLUCOSE ORAL GEL 77.4 % (<i>dextrose (diabetic use)</i>)	Preferred	
*DIAGNOSTIC TESTS***		
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP (<i>glucose blood</i>)	Preferred	PA (Eligible for auto-PA approval); QL (8 strips/day for up to 18 years old, insulin users, or pregnancy; 4 strips/day for all others); QL (10 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (<i>glucose blood</i>)	Preferred	PA (Eligible for auto-PA approval); QL (8 strips/day for up to 18 years old, insulin users, or pregnancy; 4 strips/day for all others); QL (10 EA per 1 day)
*DIARRHEA COMBINATIONS - OPIATES***		
<i>ft anti-diarrheal/anti-gas oral tablet 2-125 mg</i>	Preferred	
<i>gnp anti-diarrheal/anti-gas oral tablet 2-125 mg</i>	Preferred	
<i>goodsense anti-diarr/ant-gas oral tablet 2-125 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>loperamide-simethicone oral tablet 2-125 mg</i>	Preferred	
*DIETARY MANAGEMENT PRODUCT COMBINATIONS***		
<i>l-methylfolate forte oral capsule 15-90.314 mg, 7.5-90.314 mg</i>	Preferred	
<i>l-methyl-mc oral tablet 6-1-50-5 mg</i>	Preferred	
<i>westab max oral tablet 2.5-25-2 mg</i>	Preferred	
FOLBIC ORAL TABLET 2.5-25-2 MG (<i>fa-pyridoxine-cyanocobalamin</i>)	Preferred	
FOLBIC RF ORAL TABLET 1.13-25-2 MG (<i>l-methylfolate-b6-b12</i>)	Preferred	
FOLTANX ORAL TABLET 3-35-2 MG (<i>l-methylfolate-b6-b12</i>)	Preferred	
METAFOLBIC ORAL TABLET 6-1-50-5 MG (<i>l-methylfolate-b12-b6-b2</i>)	Preferred	
NIVA-FOL ORAL TABLET 2.5-25-2 MG (<i>fa-pyridoxine-cyanocobalamin</i>)	Preferred	
*DISPOSABLE GLOVES***		
<i>cotton gloves medium</i>	Preferred	
<i>cvs gloves</i>	Preferred	
<i>cvs gloves vinyl</i>	Preferred	
<i>cvs latex gloves small</i>	Preferred	
<i>cvs nitrile exam gloves</i>	Preferred	
<i>cvs nyplex gloves</i>	Preferred	
<i>cvs super-soft vinyl gloves</i>	Preferred	
<i>eql latex exam gloves</i>	Preferred	
<i>eql nitrile exam gloves</i>	Preferred	
<i>eql vinyl exam gloves</i>	Preferred	
<i>eql vinyl gloves one size</i>	Preferred	
<i>gnp latex exam gloves</i>	Preferred	
<i>gnp nitrile exam gloves</i>	Preferred	
<i>gnp vinyl exam gloves</i>	Preferred	
<i>latex gloves</i>	Preferred	
<i>latex gloves large</i>	Preferred	
<i>latex gloves medium</i>	Preferred	
<i>latex gloves one size</i>	Preferred	
<i>latex gloves small</i>	Preferred	
<i>lavender nitrile gloves/medium</i>	Preferred	
<i>nitrile exam gloves large</i>	Preferred	
<i>nitrile exam gloves medium</i>	Preferred	
<i>nitrile gloves large</i>	Preferred	
<i>nitrile gloves medium</i>	Preferred	
<i>nitrile gloves small</i>	Preferred	
<i>nitrile gloves x-large</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>nitrile gloves/one size</i>	Preferred	
<i>nitrile gloves/size 10</i>	Preferred	
<i>nitrile gloves/size 6</i>	Preferred	
<i>nitrile gloves/size 6.5</i>	Preferred	
<i>nitrile gloves/size 7</i>	Preferred	
<i>nitrile gloves/size 7.5</i>	Preferred	
<i>nitrile gloves/size 8</i>	Preferred	
<i>nitrile gloves/size 8.5</i>	Preferred	
<i>nitrile gloves/size 9</i>	Preferred	
<i>nitrile gloves/size 9.5 medium</i>	Preferred	
<i>powder free nitrile gloves lg</i>	Preferred	
<i>powder free nitrile gloves med</i>	Preferred	
<i>powder free nitrile gloves sm</i>	Preferred	
<i>powder free nitrile gloves xl</i>	Preferred	
<i>pro comfort gloves large</i>	Preferred	
<i>pro comfort gloves medium</i>	Preferred	
<i>pro comfort gloves x-large</i>	Preferred	
<i>pro-comfort examination gloves</i>	Preferred	
<i>ra extended cuff nitrile glove</i>	Preferred	
<i>ra heavy duty latex gloves</i>	Preferred	
<i>ra vinyl gloves</i>	Preferred	
<i>synthetic vinyl exam gloves</i>	Preferred	
<i>ultra-soft gloves</i>	Preferred	
<i>vinyl gloves</i>	Preferred	
<i>vinyl gloves medium</i>	Preferred	
<i>vinyl gloves one size</i>	Preferred	
ALLERGARD SURGICAL GLOVES (<i>disposable gloves</i>)	Preferred	
ASSURANCE VINYL EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE LARGE (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE MED (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE SMALL (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE XL (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES LARGE (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES MED (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES SMALL (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES XL (<i>disposable gloves</i>)	Preferred	
CHEMOPLUS LATEX GLOVES (<i>disposable gloves</i>)	Preferred	
CHEMOPLUS NEOPRENE GLOVE (<i>disposable gloves</i>)	Preferred	
CHEMOPLUS NITRILE GLOVES (<i>disposable gloves</i>)	Preferred	
CLEVER CHOICE COMFORT EZ GLOVE (<i>disposable gloves</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
COMFORT TOUCH VINYL GLOVES/L (<i>disposable gloves</i>)	Preferred	
COMFORT TOUCH VINYL GLOVES/M (<i>disposable gloves</i>)	Preferred	
COMFORT TOUCH VINYL GLOVES/S (<i>disposable gloves</i>)	Preferred	
DIGITEX EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
J & J HEALTH CARE GLOVES (<i>disposable gloves</i>)	Preferred	
MAXXUS ORTHO SURGICAL GLOVES (<i>disposable gloves</i>)	Preferred	
MICRO-TOUCH GLOVES (<i>disposable gloves</i>)	Preferred	
MICRO-TOUCH XP GLOVES (<i>disposable gloves</i>)	Preferred	
NEUTRALON 50 BROWN LATEX GLOVE (<i>disposable gloves</i>)	Preferred	
NEUTRALON BROWN SURGICAL GLOVE (<i>disposable gloves</i>)	Preferred	
PURE-COMFORT DISPOSABLE VINYL (<i>disposable gloves</i>)	Preferred	
PURE-COMFORT NITRILE EXAM (<i>disposable gloves</i>)	Preferred	
PURE-COMFORT SYNTHETIC NITRILE (<i>disposable gloves</i>)	Preferred	
RELION NITRILE EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-L (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-M (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-S (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-XL (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-L (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-M (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-S (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-XL (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-L (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-M (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-S (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-XL (<i>disposable gloves</i>)	Preferred	
SAFESKIN NITRILE EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
SECURE GLOVES (<i>disposable gloves</i>)	Preferred	
SHAMROCK LATEX EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
SHAMROCK VINYL EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
SURGIKOS LATEX SURGICAL GLOVES (<i>disposable gloves</i>)	Preferred	
TRANQUILITY VINYL GLOVES LARGE (<i>disposable gloves</i>)	Preferred	
TRANQUILITY VINYL GLOVES MED (<i>disposable gloves</i>)	Preferred	
TRANQUILITY VINYL GLOVES SMALL (<i>disposable gloves</i>)	Preferred	
*DIURETIC COMBINATIONS***		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	Preferred	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	Preferred	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
*DOPAMINE RECEPTOR AGONISTS***		
<i>cabergoline oral tablet 0.5 mg</i>	Preferred	
*DRY MOUTH AGENTS AND ARTIFICIAL SALIVA***		
AQUORAL MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
*ELECTROLYTES ORAL***		
<i>gnp electrolyte solution oral solution</i>	Preferred	
<i>gnp pediatric electrolyte oral solution</i>	Preferred	
<i>hydrating electrolyte oral packet</i>	Preferred	
<i>sm pediatric electrolyte oral solution</i>	Preferred	
ORALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
REHYDRALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
*EMERGENCY CONTRACEPTIVES***		
<i>levonorgestrel oral tablet 1.5 mg</i>	Preferred	
AFTERA ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
AFTERPILL ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
CURAE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
HER STYLE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
MY CHOICE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
MY WAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
NEW DAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
REACT ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
TAKE ACTION ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
*EMOLLIENT COMBINATIONS***		
<i>mineral oil-hydrophil petrolat external ointment</i>	Preferred	
*EMOLLIENT/KERATOLYTIC AGENTS***		
<i>urea 20 intensive hydrating external cream 20 %</i>	Preferred	
<i>urea external cream 20 %</i>	Preferred	
<i>ureacin-10 external lotion 10 %</i>	Preferred	
<i>ureacin-20 external cream 20 %</i>	Preferred	
NUTRAPLUS EXTERNAL CREAM 10 % (<i>urea</i>)	Preferred	
NUTRAPLUS EXTERNAL LOTION 10 % (<i>urea</i>)	Preferred	
*EMOLLIENTS***		
<i>a&d external ointment</i>	Preferred	
<i>ammonium lactate external cream 12 %</i>	Preferred	
<i>ammonium lactate external lotion 12 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm dry skin therapy external lotion</i>	Preferred	
<i>thera-derm external lotion</i>	Preferred	
<i>vitamin a & d external ointment</i>	Preferred	
AMLACTIN DAILY EXTERNAL LOTION 12 % (<i>ammonium lactate</i>)	Preferred	
AQUA GLYCOLIC HAND/BODY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
AQUA LACTEN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
AQUAMED EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CAM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CORN HUSKERS EXTERNAL LOTION (<i>emollient</i>)	Preferred	
DML EXTERNAL LOTION (<i>emollient</i>)	Preferred	
LUBRISOFT EXTERNAL LOTION (<i>emollient</i>)	Preferred	
MINERIN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NUTRADERM ADVANCED FORMULA EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NUTRADERM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
WIBI EXTERNAL LOTION (<i>emollient</i>)	Preferred	
*ESTROGEN & PROGESTIN***		
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	Preferred	QL (1 EA per 1 day)
<i>estradiol-norethindrone acet (Mimvey Oral Tablet 1-0.5 Mg)</i>	Preferred	QL (1 EA per 1 day)
*ESTROGENS***		
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	Preferred	QL (0.29 EA per 1 day)
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	Preferred	QL (0.15 EA per 1 day)
<i>estradiol valerate intramuscular oil 40 mg/ml</i>	Preferred	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (<i>estradiol</i>)	Preferred	QL (0.29 EA per 1 day)
<i>estradiol (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)</i>	Preferred	QL (0.29 EA per 1 day)
<i>estradiol (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)</i>	Preferred	QL (0.29 EA per 1 day)
*EXPECTORANTS***		
<i>chest congestion relief oral liquid 100 mg/5ml</i>	Preferred	
<i>chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>ft chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>ft mucus relief 12hr oral tablet extended release 12 hour 1200 mg, 600 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ft tussin adult oral liquid 200 mg/10ml</i>	Preferred	
<i>gnp mucus er oral tablet extended release 12 hour 1200 mg, 600 mg</i>	Preferred	
<i>gnp mucus relief oral tablet 400 mg</i>	Preferred	
<i>gnp tab tussin oral tablet 400 mg</i>	Preferred	
<i>gnp tussin mucus & chest cong oral liquid 100 mg/5ml</i>	Preferred	
<i>goodsense mucus er maximum str oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>goodsense mucus er oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>guaifenesin er oral tablet extended release 12 hour 1200 mg, 600 mg</i>	Preferred	
<i>guaifenesin oral liquid 100 mg/5ml</i>	Preferred	
<i>guaifenesin oral tablet 200 mg</i>	Preferred	
<i>mucus & chest congestion oral liquid 200 mg/10ml</i>	Preferred	
<i>mucus relief er oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>mucus relief max st oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>siltussin sa oral liquid 100 mg/5ml</i>	Preferred	
<i>sm chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>sm mucus relief childrens oral liquid 100 mg/5ml</i>	Preferred	
<i>sm mucus relief max strength oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>sm mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>sm tussin mucus+chest congest oral liquid 100 mg/5ml</i>	Preferred	
<i>tussin mucus & chest congest oral liquid 100 mg/5ml</i>	Preferred	
<i>tussin mucus+chest congestion oral liquid 100 mg/5ml</i>	Preferred	
TUSNEL-EX ORAL LIQUID 100 MG/5ML (<i>guaifenesin</i>)	Preferred	
*EXTENDED-CYCLE CONTRACEPTIVES - ORAL***		
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day (Iclevia Oral Tablet 0.15-0.03 Mg)</i>	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
*EXTERNAL VEHICLE INGREDIENTS***		
<i>methylcellulose powder</i>	Preferred	
*FIXED OILS***		
<i>castor oil oil</i>	Preferred	
<i>qc castor oil oil</i>	Preferred	
<i>sesame oil oil</i>	Preferred	
*FLAVORING AGENTS***		
<i>almond oil bitter flavor liquid</i>	Preferred	
<i>anise extract liquid</i>	Preferred	
<i>apple flavor liquid</i>	Preferred	
<i>apricot flavor liquid</i>	Preferred	
<i>bacon flavor liquid</i>	Preferred	
<i>banana concentrate liquid</i>	Preferred	
<i>banana cream flavor liquid</i>	Preferred	
<i>banana creme flavor liquid</i>	Preferred	
<i>banana flavor liquid</i>	Preferred	
<i>beef (grilled) flavor oil sol liquid</i>	Preferred	
<i>beef braised natural flavor liquid</i>	Preferred	
<i>beef flavor liquid</i>	Preferred	
<i>beef type flavor natural liquid</i>	Preferred	
<i>beef type flavor os liquid</i>	Preferred	
<i>bitter stop flavor liquid</i>	Preferred	
<i>bitterness mask flavor liquid</i>	Preferred	
<i>bitterness suppressor flavor liquid</i>	Preferred	
<i>blackberry flavor liquid</i>	Preferred	
<i>blood orange os liquid</i>	Preferred	
<i>blueberry flavor liquid</i>	Preferred	
<i>bubble gum concentrate liquid</i>	Preferred	
<i>bubble gum flavor liquid</i>	Preferred	
<i>bubble gum os liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>bubble gum ws liquid</i>	Preferred	
<i>butter flavor liquid</i>	Preferred	
<i>butter rum flavor liquid</i>	Preferred	
<i>butterscotch flavor liquid</i>	Preferred	
<i>caramel flavor liquid</i>	Preferred	
<i>caramel os liquid</i>	Preferred	
<i>cheesecake flavor liquid</i>	Preferred	
<i>cherry flavor liquid</i>	Preferred	
<i>chicken (grilled) flavor liquid</i>	Preferred	
<i>chicken conc flavor liquid</i>	Preferred	
<i>chicken flavor liquid</i>	Preferred	
<i>chicken flavor oil miscible liquid</i>	Preferred	
<i>chicken flavor oil soluble liquid</i>	Preferred	
<i>chicken flavor water miscible liquid</i>	Preferred	
<i>chicken roasted concentrate liquid</i>	Preferred	
<i>chocolate flavor liquid</i>	Preferred	
<i>chocolate hazelnut flavor liquid</i>	Preferred	
<i>coconut flavor liquid</i>	Preferred	
<i>coffee flavor liquid</i>	Preferred	
<i>cola flavor liquid</i>	Preferred	
<i>cotton candy flavor liquid</i>	Preferred	
<i>cran-raspberry flavor liquid</i>	Preferred	
<i>creme de menthe flavor liquid</i>	Preferred	
<i>creme dementhe flavor liquid</i>	Preferred	
<i>creme os liquid</i>	Preferred	
<i>english toffee flavor liquid</i>	Preferred	
<i>eugenol flavor liquid</i>	Preferred	
<i>fish flavor liquid</i>	Preferred	
<i>grape concord os liquid</i>	Preferred	
<i>grape flavor liquid</i>	Preferred	
<i>green apple os liquid</i>	Preferred	
<i>guava flavor liquid</i>	Preferred	
<i>ham flavor liquid</i>	Preferred	
<i>honey flavor liquid</i>	Preferred	
<i>kahlua flavor liquid</i>	Preferred	
<i>lemon extract liquid</i>	Preferred	
<i>lemon flavor liquid</i>	Preferred	
<i>licorice flavor liquid</i>	Preferred	
<i>liver concentrate liquid</i>	Preferred	
<i>liver flavor liquid</i>	Preferred	

Drug Name	Formulary Status	Requirements/Limits
<i>mango flavor liquid</i>	Preferred	
<i>mango passion fruit os liquid</i>	Preferred	
<i>maple flavor liquid</i>	Preferred	
<i>marshmallow flavor liquid</i>	Preferred	
<i>marshmallow os liquid</i>	Preferred	
<i>mint chocolate chip flavor liquid</i>	Preferred	
<i>natural caramel liquid</i>	Preferred	
<i>orange concentrate liquid</i>	Preferred	
<i>orange cream flavor liquid</i>	Preferred	
<i>orange flavor liquid</i>	Preferred	
<i>orange oil flavor liquid</i>	Preferred	
<i>peach flavor liquid</i>	Preferred	
<i>peanut butter flavor liquid</i>	Preferred	
<i>peppermint burst os liquid</i>	Preferred	
<i>pina colada flavor liquid</i>	Preferred	
<i>pineapple flavor liquid</i>	Preferred	
<i>pralines and cream flavor liquid</i>	Preferred	
<i>pumpkin flavor liquid</i>	Preferred	
<i>raspberry flavor liquid</i>	Preferred	
<i>raspberry os liquid</i>	Preferred	
<i>root beer flavor liquid</i>	Preferred	
<i>sardine flavor liquid</i>	Preferred	
<i>shrimp flavor liquid</i>	Preferred	
<i>spearmint os liquid</i>	Preferred	
<i>stevia glycerite extract liquid</i>	Preferred	
<i>strawberry flavor liquid</i>	Preferred	
<i>strawberry os liquid</i>	Preferred	
<i>sweetening enhancer liquid</i>	Preferred	
<i>tropical fusion os liquid</i>	Preferred	
<i>tropical punch flavor liquid</i>	Preferred	
<i>tuna flavor liquid</i>	Preferred	
<i>tuna type flavor os liquid</i>	Preferred	
<i>tutti frutti flavor liquid</i>	Preferred	
<i>tutti-frutti flavor liquid</i>	Preferred	
<i>vanilla butternut flavor liquid</i>	Preferred	
<i>vanilla flavor liquid</i>	Preferred	
<i>vanilla os liquid</i>	Preferred	
<i>very berry os liquid</i>	Preferred	
<i>vitamin/iron masking agent liquid</i>	Preferred	
<i>watermelon flavor liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>wild cherry flavor liquid</i>	Preferred	
<i>wild cherry os liquid</i>	Preferred	
FLAVORX LIQUID (<i>flavoring agent</i>)	Preferred	
MARSHMALLOW WS LIQUID (<i>flavoring agent</i>)	Preferred	
PCCA SWEETNESS ENHANCER LIQUID (<i>flavoring agent</i>)	Preferred	
SWEET DROPS LIQUID (<i>flavoring agent</i>)	Preferred	
TROPICAL FUSION WS LIQUID (<i>flavoring agent</i>)	Preferred	
*FLUORIDE DENTAL PRODUCTS***		
<i>fraiche 5000 dental dental gel 1.1 %</i>	Preferred	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	Preferred	
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	Preferred	
<i>sodium fluoride 5000 ppm dental gel 1.1 %</i>	Preferred	
<i>sodium fluoride dental gel 1.1 %</i>	Preferred	
<i>sodium fluoride (Denta 5000 Plus Dental Cream 1.1 %)</i>	Preferred	
<i>sodium fluoride (Dentagel Dental Gel 1.1 %)</i>	Preferred	
*FLUORIDE***		
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	Preferred	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	Preferred	
SOLUVITA ORAL SOLUTION 0.5 MG/ML (<i>sodium fluoride</i>)	Preferred	
*FOLIC ACID ANTAGONISTS RESCUE AGENTS***		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	Preferred	
*FOLIC ACID/FOLATES***		
<i>folic acid oral tablet 1 mg</i>	Preferred	
<i>sm folic acid oral tablet 400 mcg</i>	Preferred	
<i>true folic acid oral tablet 1 mg, 400 mcg</i>	Preferred	
*FOUR PHASE CONTRACEPTIVES - ORAL***		
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	Preferred	Max 365-day supply per 1 Fill
*GENITOURINARY IRRIGANTS***		
<i>acetic acid irrigation solution 0.25 %</i>	Preferred	
<i>sodium chloride irrigation solution 0.9 %</i>	Preferred	
*GLUCOSE MONITORING TEST SUPPLIES***		
<i>acti-lance 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>acti-lance lite lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>acti-lance special lancets 17g</i>	Preferred	Max 100-day supply per 1 Fill
<i>acti-lance universal 23g</i>	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
<i>adjustable lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>advanced mobile lancet</i>	Preferred	Max 100-day supply per 1 Fill
<i>aimsco twist lancets 32g</i>	Preferred	Max 100-day supply per 1 Fill
<i>assure comfort lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>aurora lancet super thin 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>aurora lancet thin 23g</i>	Preferred	Max 100-day supply per 1 Fill
<i>careone advanced lancing dev</i>	Preferred	Max 100-day supply per 1 Fill
<i>careone lancet thin 23g</i>	Preferred	Max 100-day supply per 1 Fill
<i>comfort assured lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>comfort assured lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancets 21g</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancets micro thin 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancets original</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancets thin 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancets ultra thin 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancets ultra-thin 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>cvs ultra thin lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>drug mart lancets thin 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i>easy comfort lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>easy comfort lancets twist top</i>	Preferred	Max 100-day supply per 1 Fill
<i>easy mini eject lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>easy mini lancing device</i>	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>embrace lancing device/ejector</i>	Preferred	Max 100-day supply per 1 Fill
<i>eql color lancets 21g</i>	Preferred	Max 100-day supply per 1 Fill
<i>eql color lancets micro 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>eql super thin lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>eql thin lancets 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i>global inject ease lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>global inject ease lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>global lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>gnp lancets 21g</i>	Preferred	Max 100-day supply per 1 Fill
<i>gnp lancets thin 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i>gnp sterile lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>gnp sterile lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>gnp sterile lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense color lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense lancets 26g univ</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense lancets 30g univ</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense lancets 33g univ</i>	Preferred	Max 100-day supply per 1 Fill
<i>goodsense lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>h-e-b incontrol adv lancing</i>	Preferred	Max 100-day supply per 1 Fill
<i>h-e-b incontrol lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>h-e-b incontrol lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
<i>h-e-b incontrol lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>hy-vee thin lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>kinney lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>kinney thin lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets 21g</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets micro thin 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets super thin</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets thin</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets thin 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancets ultrathin 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i> Kroger lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancet device</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancet device with ejector</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets micro thin 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets super thin 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets thin</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancets ultra thin 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i> lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i> leader advanced lancing device</i>	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>lite touch lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>live better lancet super thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>longs lancets standard</i>	Preferred	Max 100-day supply per 1 Fill
<i>longs lancets thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>longs lancets ultra thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>medichoice safety lancet</i>	Preferred	Max 100-day supply per 1 Fill
<i>medichoice safety lancet extra</i>	Preferred	Max 100-day supply per 1 Fill
<i>medichoice safety lancet norm</i>	Preferred	Max 100-day supply per 1 Fill
<i>mini lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>multi-lancet device</i>	Preferred	Max 100-day supply per 1 Fill
<i>pip lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>pip lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>preferred plus lancets colored</i>	Preferred	Max 100-day supply per 1 Fill
<i>preferred plus lancets thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>pro comfort lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>pro comfort lancets 31g</i>	Preferred	Max 100-day supply per 1 Fill
<i>pro comfort safety lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>pure comfort lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>px advanced lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>px lancets microthin 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>px lancets ultra thin 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>qc advanced lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>qc lancets super thin 30g</i>	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
<i>qc lancets ultra thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>qc unilet lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>qc unilet lancets micro thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>reality lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>reality trigger lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>safety lancet 30g/pressure act</i>	Preferred	Max 100-day supply per 1 Fill
<i>safety lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>saps health plus lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>saps health twist top lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>saps twist top lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>saps scare twist top lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>sb lancets thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>sb lancets ultra thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>select-lite device/lancets kit</i>	Preferred	Max 100-day supply per 1 Fill
<i>select-lite lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>sm lancets 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>super thin lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort lancets 18g</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort lancets 21g</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort lancets 23g</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>sure comfort lancing pen</i>	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>tgt lancet micro thin 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>tgt lancet thin 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i>tgt lancet ultra thin 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>tgt lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>todays health lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>todays health thin lancets 28g</i>	Preferred	Max 100-day supply per 1 Fill
<i>todays health thin lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>topcare lancets micro-thin 33g</i>	Preferred	Max 100-day supply per 1 Fill
<i>true comfort safety lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>true comfort twist top lancets</i>	Preferred	Max 100-day supply per 1 Fill
<i>twist top lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>ultra thin lancets 31g</i>	Preferred	Max 100-day supply per 1 Fill
<i>ultra-care lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
<i>value plus lancet standard 21g</i>	Preferred	Max 100-day supply per 1 Fill
<i>value plus lancets super thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>value plus lancets thin 26g</i>	Preferred	Max 100-day supply per 1 Fill
<i>value plus lancing device</i>	Preferred	Max 100-day supply per 1 Fill
<i>walgreens lancets micro thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>walgreens lancets super thin</i>	Preferred	Max 100-day supply per 1 Fill
<i>zevrx twist top lancets 30g</i>	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK FASTCLIX LANCET KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK FASTCLIX LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK SAFE-T PRO LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
ACCU-CHEK SOFTCLIX LANCET DEV KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK SOFTCLIX LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE RAPID-SAFE LANCING (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
AGAMATRIX ULTRA-THIN LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
AIMSCO TWIST LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
AQUALANCE LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE PLUS SAFETY 25G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE PLUS SAFETY 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE SAFETY LANCET 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
AUTO-LANCET (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
AUTO-LANCET MINI (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
AUTOLET II CLINISAFE KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
AUTOLET LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
AUTOLET LITE CLINISAFE KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
AUTOLET LITE STARTER PACK KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
AUTOLET MINI (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
AUTOLET PLATFORMS (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
AUTOLET PLUS (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
BD MICROTAINER LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARDIOCOM LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
CAREONE LANCET SUPER THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARESENS LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARESENS LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH LANCING/EJECTOR (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST MC LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CHOSEN LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CHOSEN LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
CHOSEN SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CLEANLET LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHEK LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE COMFORT EZ (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE LANCETS 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
COAGUCHEK LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH LANCETS 31G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH PLUS LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH PLUS LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH TWIST LANCET 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DEXCOM G5 MOB/G4 PLAT SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (4 EA per 28 days)
DEXCOM G5 MOBILE RECEIVER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G5 MOBILE TRANSMITTER (<i>continuous glucose transmitter</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 90 days); 90-day fill allowed after two 1-month fills
DEXCOM G5 RECEIVER KIT DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 90 days); 90-day fill allowed after two 1-month fills
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 30 days)
DIATHRIVE LANCET ULTRA THIN 30 (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DIATHRIVE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DIATHRIVE LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
DROPLET GENTEEL LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
DROPLET LANCETS ULTRA THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DROPLET LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
DROPLET PERSONAL LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DRUG MART ON-THE-GO LANCET 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DRUG MART UNILET LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DRUG MART UNILET LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
DRUG MART UNILET LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 28G/TWIST (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 30G/TWIST (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 32G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 32G/TWIST (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 33G/TWIST (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
EMBRACE LANCETS ULTRA THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EMBRACE PRESSURE ACTIVATED 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EMBRACE PRESSURE ACTIVATED 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCET MICRO-THIN 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCET SUPER THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCETS THIN 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
FIFTY50 SAFETY SEAL LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
FIFTY50 UNILET LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
FINGERSTIX LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
FORA LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
FORA LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
FREESTYLE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
FREESTYLE LIBRE SENSOR SYSTEM (<i>continuous glucose sensor</i>)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE UNISTICK II LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL BUTTERFLY TOUCH LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (BLUE) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (CLEAR) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (GREEN) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (ORANGE) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (RAINBOW) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (VIOLET) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (YELLOW) (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL LANCING KIT (BLUE) KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL NOZZLES (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING (BLACK) (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING (PURPLE) (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
GENTEEL PLUS LANCING (WHITE) (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING DEV(BLUE) (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING DEV(PINK) (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
GLUCOCOM LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
GLUCOCOM LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
GLUCOCOM LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
GNP LANCING SYSTEM DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
GOJJI LANCING DEVICE/CLEAR CAP (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
GOJJI STERILE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE LOW FLOW LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS HIGH FLOW (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS LOW FLOW (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS MAX FLOW (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS PEDIATRIC FLOW (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
HEALTH CARE LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
HYPOLANCE AST LANCING KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
HY-VEE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
IN TOUCH LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
IN TOUCH STERILE LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
KROGER AUTOLET LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
KROGER HEALTHPRO LANCET 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
LANCETS SUPER THIN (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
LANCETS ULTRA THIN (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
LANZO (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
LIBERTY MEDICAL LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
LIBERTY MINI LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
LITE TOUCH LANCING PEN (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
LITETOUCH LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS EXTRA 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS LITE 25G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS SPECIAL 0.8MM (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS SUPERLITE 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS UNIVERSAL 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS THIN (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS UNIVERSAL 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS UNIVERSAL 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS UNIVERSAL 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MEIJER SUPER THIN LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MICROLET LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MICROLET NEXT LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
MM LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
MM TWIST LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MONOLET LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
MONOLET OPD LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MONOLETTOR SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
MULTI-LANCET DEVICE 2 KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
MYGLUCOHEALTH LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
NOVA SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
NOVA SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
NOVA SUREFLEX LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
NOVA SUREFLEX LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA PLUS LANCET30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA PLUS LANCET33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA PLUS LANCING (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA SAFETY LANCING (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH ULTRASOFT 2 LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PERFECT LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PERFECT LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PERFECT POINT SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PHARMACIST CHOICE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PHARMACY COUNTER LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PRODIGY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PRODIGY LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
PRODIGY SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
PRODIGY TWIST TOP LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RA E-ZJECT LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
RA E-ZJECT LANCETS THIN 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RA E-ZJECT LANCETS THIN 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RA E-ZJECT LANCETS ULTRA THIN (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
READYLANCER SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCET DEVICES 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS MICRO-THIN 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS THIN 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS ULTRA-THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
RELION LANCING DEVICE KIT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
RELION ULTRA THIN LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RELION ULTRA THIN PLUS LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
REXALL LANCETS ULTRA THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
RIGHTEST ALTERNATE SITE ADAPT (<i>lancets misc.</i>)	Preferred	Max 100-day supply per 1 Fill
RIGHTEST GD500 LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
RIGHTEST GL300 LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SAFETY LANCETS 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SIMPLE DIAGNOSTICS LANCING DEV (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
SINGLE-LET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SM TRUEDRAW LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
SMART DIABETES VANTAGE LANCING (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE COLOR LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE STANDARD LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE SUPER THIN LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE THIN LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SMARTTEST LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SOLUS V2 LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SOLUS V2 LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
SOLUS V2 TWIST LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
STERILANCE TL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
SURELITE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TECHLITE AST LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TECHLITE LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TECHLITE LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TRAVEL LANCETS ADVANCED 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW (<i>blood glucose calibration</i>)	Preferred	
TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (<i>blood glucose calibration</i>)	Preferred	
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (<i>blood glucose calibration</i>)	Preferred	
TRUEDRAW LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
TRUEPLUS SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ULTI-LANCE AUTOMATIC (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
ULTILET CLASSIC LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ULTILET LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ULTILET SAFETY LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ULTILET SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ULTRA-THIN II AUTO LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
ULTRA-THIN II LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET COMFORTOUCH LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET EXCELITE (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET EXCELITE II (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET G.P. LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET G.P. SUPERLITE LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET GP 28 ULTRA THIN (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET MICRO-THIN 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET SUPERLITE LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET SUPER-THIN 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNILET ULTRA-THIN 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 1 (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 COMFORT (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 EXTRA (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
UNISTIK 2 NEONATAL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 NORMAL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 SUPER (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 COMFORT (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 EXTRA (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 GENTLE (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 NEONATAL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 NORMAL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK CZT COMFORT (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK CZT NORMAL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK NORMAL (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK PRO SAFETY LANCET (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK SAFETY LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNIVERSAL 1 LANCETS THIN 26G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNIVERSAL 1 LANCETS THIN 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
UNIVERSAL 1 LANCETS ULTRA THIN (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VERIFINE SAFE LANCET MINI 21G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
VERIFINE SAFE LANCET MINI 23G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VERIFINE SAFE LANCET MINI 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VERIFINE SAFE LANCET MINI 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VERIFINE UNIVERSAL LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VERIFINE UNIVERSAL LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VERIFINE UNIVERSAL LANCETS 33G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD LANCETS 30G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD LANCING DEVICE (<i>lancet devices</i>)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
WALGREENS LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
WALGREENS THIN LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
WALGREENS ULTRA THIN LANCETS (<i>lancets</i>)	Preferred	Max 100-day supply per 1 Fill
*HEMATORHEOLOGIC AGENTS***		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	Preferred	
*HEMOSTATICS - SYSTEMIC***		
<i>tranexamic acid oral tablet 650 mg</i>	Preferred	QL (6 EA per 1 day)
*HEPATITIS C AGENTS***		
<i>ribavirin oral capsule 200 mg</i>	Preferred	SP; QL (6 EA per 1 day)
<i>ribavirin oral tablet 200 mg</i>	Preferred	SP; QL (6 EA per 1 day)
*HUMIDIFIERS***		
<i>sm vaporizer cleaning tablet soluble</i>	Preferred	
<i>sm vaporizer inhalant liquid</i>	Preferred	
GORDO-POOL CONCENTRATE (<i>humidifier/vaporizer supplies</i>)	Preferred	
KAZ BACTERIOSTATIC TREATMENT LIQUID (<i>humidifier/vaporizer supplies</i>)	Preferred	
KAZ INHALANT LIQUID (<i>humidifier/vaporizer supplies</i>)	Preferred	
KAZ WATER TREATMENT LIQUID (<i>humidifier/vaporizer supplies</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
*HYDROLYTIC ENZYMES***		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	Preferred	SP; PA; QL (5 ML per 1 day)
*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS***		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	Preferred	
*IMIDAZOLE-RELATED ANTIFUNGALS***		
<i>3 day vaginal vaginal cream 2 %</i>	Preferred	
<i>clotrimazole vaginal cream 1 %</i>	Preferred	
<i>ft clotrimazole 3 vaginal cream 2 %</i>	Preferred	
<i>ft clotrimazole vaginal cream 1 %</i>	Preferred	
<i>ft miconazole 3 comb pack-supp vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>ft miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>ft miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>ft tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
<i>gnp clotrimazole 3 vaginal cream 2 %</i>	Preferred	
<i>gnp miconazole 1 vaginal kit 1200 & 2 mg & %</i>	Preferred	
<i>gnp miconazole 3 vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>gnp miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>miconazole 3 combo-supp vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>miconazole 7 vaginal suppository 100 mg</i>	Preferred	
<i>miconazole nitrate vaginal cream 2 %</i>	Preferred	
<i>sm 3-day vaginal vaginal cream 2 %</i>	Preferred	
<i>sm clotrimazole vaginal vaginal cream 1 %</i>	Preferred	
<i>sm miconazole 3 applicator vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>sm miconazole 3 vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>sm miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>sm miconazole 7 vaginal suppository 100 mg</i>	Preferred	
<i>sm tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	Preferred	
<i>terconazole vaginal suppository 80 mg</i>	Preferred	QL (1.5 EA per 1 day)
<i>tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
*IMIDAZOTETRAZINES***		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	Preferred	SP; PA
*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL***		
<i>imiquimod external cream 5 %</i>	Preferred	QL (0.434 EA per 1 day); AGE (Min 12 Years)

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Drug Name	Formulary Status	Requirements/Limits
*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS***		
<i>mycophenolate mofetil oral capsule 250 mg</i>	Preferred	
<i>mycophenolate mofetil oral tablet 500 mg</i>	Preferred	
*INSULIN ADMINISTRATION SUPPLIES***		
AMBI-TRAY (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/ADMELOG (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/APIDRA (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/ASPART (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/BASAGLAR (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/FIASP (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/HUMALOG (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/LANTUS (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/LISPRO (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/LYUMJEV (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/NOVOLOG (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/TOUJEO (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/TOUJEO M (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/TRESIBA (<i>insulin admin supplies</i>)	Preferred	
EASY TOUCH INSULIN BARRELS 1ML (<i>insulin admin supplies</i>)	Preferred	
INSUL-CAP (<i>insulin admin supplies</i>)	Preferred	
INSUL-EZE (<i>insulin admin supplies</i>)	Preferred	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD 5 LIBRE2 PLUS G6 KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD 5 LIBRE2 PLUS G6 PODS (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD CLASSIC PODS (GEN 3) (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD DASH INTRO (GEN 4) KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD DASH PDM (GEN 4) KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD DASH PODS (GEN 4) (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD GO KIT 20 UNIT/24HR, 30 UNIT/24HR, 40 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD POD PALS (<i>insulin dispos pmp accessories</i>)	Preferred	PA
PRODIGY COUNT-A-DOSE (<i>insulin admin supplies</i>)	Preferred	
V-GO 20 KIT 20 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
V-GO 30 KIT 30 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
V-GO 40 KIT 40 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
VIVI CAP (<i>insulin admin supplies</i>)	Preferred	
VIVI CAP1 (<i>insulin admin supplies</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
*INTESTINAL ACIDIFIERS***		
<i>enulose oral solution 10 gm/15ml</i>	Preferred	
<i>generlac oral solution 10 gm/15ml</i>	Preferred	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	Preferred	
*IODINE ANTISEPTICS***		
<i>first aid antiseptic external ointment 10 %</i>	Preferred	
<i>gnp povidone-iodine external solution 10 %</i>	Preferred	
<i>povidone-iodine external solution 10 %</i>	Preferred	
<i>sm povidone-iodine external solution 10 %</i>	Preferred	
BETADINE EXTERNAL SOLUTION 10 % (<i>povidone-iodine</i>)	Preferred	
BETADINE SURGICAL SCRUB EXTERNAL SOLUTION 7.5 % (<i>povidone-iodine</i>)	Preferred	
*IRON COMBINATIONS***		
<i>ferocon oral capsule</i>	Preferred	
<i>foltrin oral capsule</i>	Preferred	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	Preferred	
FOLITAB 500 ORAL TABLET EXTENDED RELEASE 105-500-0.8 MG (<i>ferrous sulfate-c-folic acid</i>)	Preferred	
*IRON***		
<i>ferrous fumarate oral tablet 324 mg</i>	Preferred	
<i>ferrous gluconate oral tablet 324 (38 fe) mg</i>	Preferred	
<i>ferrous sulfate oral solution 220 (44 fe) mg/5ml, 300 (60 fe) mg/5ml, 300 mg/6.8ml, 75 (15 fe) mg/ml</i>	Preferred	
<i>ferrous sulfate oral tablet 325 (65 fe) mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ferrous sulfate oral tablet delayed release 324 (65 fe) mg, 325 (65 fe) mg</i>	Preferred	
<i>gnp iron oral tablet 200 (65 fe) mg</i>	Preferred	
<i>gnp iron oral tablet extended release 45 mg</i>	Preferred	
<i>iron (ferrous sulfate) oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron chews pediatric oral tablet chewable 15 mg</i>	Preferred	
<i>iron infant/toddler oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>polysaccharide iron complex oral capsule 150 mg</i>	Preferred	
<i>sm iron oral tablet 325 (65 fe) mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm iron slow release oral tablet extended release 160 (50 fe) mg</i>	Preferred	
<i>sm slow release iron oral tablet extended release 143 (45 fe) mg</i>	Preferred	
<i>true ferrous sulfate oral tablet delayed release 324 mg</i>	Preferred	
<i>wee care oral suspension 15 mg/1.25ml</i>	Preferred	
FERATE ORAL TABLET 240 (27 FE) MG (<i>ferrous gluconate</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
FEROSUL ORAL TABLET 325 (65 FE) MG (<i>ferrous sulfate</i>)	Preferred	90-day fill allowed after two 1-month fills
FERREX 150 ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	Preferred	
FERRIMIN 150 ORAL TABLET 150 MG (<i>ferrous fumarate</i>)	Preferred	
FERROCITE ORAL TABLET 324 MG (<i>ferrous fumarate</i>)	Preferred	
NU-IRON ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	Preferred	
*IRRIGATION SOLUTIONS***		
<i>sterile water for irrigation irrigation solution</i>	Preferred	
<i>water for irrigation, sterile irrigation solution</i>	Preferred	
*KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS***		
<i>podofilox external solution 0.5 %</i>	Preferred	
<i>therapeutic dandruff external shampoo 3 %</i>	Preferred	
DHS SAL EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
*LAXATIVES - MISCELLANEOUS***		
<i>constulose oral solution 10 gm/15ml</i>	Preferred	
<i>ft clearlax oral powder 17 gm/scoop</i>	Preferred	
<i>gavilax oral powder 17 gm/scoop</i>	Preferred	
<i>glycerin (adult) rectal suppository 2 gm</i>	Preferred	
<i>glycerin adult rectal suppository 2 gm</i>	Preferred	
<i>glycerin childrens rectal suppository 1 gm, 1.2 gm</i>	Preferred	
<i>gnp glycerin (adult) rectal suppository 2.1 gm</i>	Preferred	
<i>gnp glycerin child rectal suppository 1.2 gm</i>	Preferred	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	Preferred	
<i>peg 3350 oral packet 17 gm</i>	Preferred	
<i>peg 3350 oral powder 17 gm/scoop</i>	Preferred	
<i>polyethylene glycol 3350 oral packet 17 gm</i>	Preferred	
<i>polyethylene glycol 3350 oral powder 17 gm/scoop</i>	Preferred	
<i>sm glycerin pediatric rectal suppository 1.2 gm, 80.7 %</i>	Preferred	
<i>true laxative oral powder 17 gm/scoop</i>	Preferred	
CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
FLEET LIQUID GLYCERIN SUPP RECTAL ENEMA 5.4 GM/DOSE (<i>glycerin (laxative)</i>)	Preferred	
GLYCOLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
GNP CLEARLAX ORAL PACKET 17 GM (<i>polyethylene glycol 3350</i>)	Preferred	
GNP CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
GOODSENSE CLEARLAX ORAL POWDER 17 GM/SCOOP (polyethylene glycol 3350)	Preferred	
HEALTHYLAX ORAL PACKET 17 GM (polyethylene glycol 3350)	Preferred	
HM CLEARLAX ORAL POWDER 17 GM/SCOOP (polyethylene glycol 3350)	Preferred	
PEDIA-LAX RECTAL SUPPOSITORY 2.8 GM (glycerin (laxative))	Preferred	
SM CLEARLAX ORAL POWDER 17 GM/SCOOP (polyethylene glycol 3350)	Preferred	
*LAXATIVES & DSS***		
ft senna-s oral tablet 8.6-50 mg	Preferred	
ft stool softener oral tablet 50-8.6 mg	Preferred	
gnp senna plus oral tablet 8.6-50 mg	Preferred	
gnp stool softener/laxative oral tablet 8.6-50 mg	Preferred	
hm stool softener/laxative oral tablet 8.6-50 mg	Preferred	
senexon-s oral tablet 8.6-50 mg	Preferred	
senna plus oral tablet 8.6-50 mg	Preferred	
senna-docusate sodium oral tablet 8.6-50 mg	Preferred	
senna-time s oral tablet 8.6-50 mg	Preferred	
sennosides-docusate sodium oral tablet 8.6-50 mg	Preferred	
sm senna-s oral tablet 8.6-50 mg	Preferred	
sm stool softener/laxative oral tablet 8.6-50 mg	Preferred	
stimulant laxative oral tablet 8.6-50 mg	Preferred	
stool softener plus laxative oral tablet 8.6-50 mg	Preferred	
COLACE 2-IN-1 ORAL TABLET 8.6-50 MG (sennosides-docusate sodium)	Preferred	
SEKOKOT S ORAL TABLET 8.6-50 MG (sennosides-docusate sodium)	Preferred	
*LEPROSTATICS***		
dapsone oral tablet 100 mg, 25 mg	Preferred	
*LEVODOPA COMBINATIONS***		
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	Preferred	90-day fill allowed after two 1-month fills
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	Preferred	90-day fill allowed after two 1-month fills
carbidopa-levodopa oral tablet dispersible 10-100 mg	Preferred	90-day fill allowed after two 1-month fills
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	Preferred	
DHIVY ORAL TABLET 25-100 MG (carbidopa-levodopa)	Preferred	90-day fill allowed after two 1-month fills
*LINCOSAMIDES***		
clindamycin hcl oral capsule 150 mg, 300 mg	Preferred	QL (4 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	Preferred	QL (70 ML per 1 day)
*LOCAL ANESTHETICS - TOPICAL***		
<i>ft pain relief max strength external patch 4 %</i>	Preferred	
<i>gnp lidocaine pain relief external patch 4 %</i>	Preferred	
<i>gnp lidocaine pain relieving external cream 4 %</i>	Preferred	
<i>lidocaine external cream 4 %</i>	Preferred	
<i>lidocaine external patch 4 %</i>	Preferred	
<i>lidocaine pain relief external patch 4 %</i>	Preferred	
<i>lidocaine pain relief max st external cream 4 %</i>	Preferred	
<i>lidocaine pain relief max st external patch 4 %</i>	Preferred	
<i>lidocaine pain relieving external patch 4 %</i>	Preferred	
<i>true lido external cream 4 %</i>	Preferred	
<i>ultra lido external cream 4 %</i>	Preferred	
<i>ultra lido external patch 4 %</i>	Preferred	
*LOOP DIURETICS***		
<i>bumetanide oral tablet 0.5 mg, 1 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>bumetanide oral tablet 2 mg</i>	Preferred	QL (5 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	Preferred	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
*LUBRICANT LAXATIVES***		
<i>enema mineral oil rectal enema</i>	Preferred	
<i>ft enema mineral oil rectal enema</i>	Preferred	
<i>ft mineral oil oral oil</i>	Preferred	
<i>gnp mineral oil oral oil</i>	Preferred	
<i>hm enema mineral oil rectal enema</i>	Preferred	
<i>mineral oil oral oil</i>	Preferred	
<i>sm mineral oil rectal enema</i>	Preferred	
*MACROLIDE IMMUNOSUPPRESSANTS***		
<i>sirolimus oral solution 1 mg/ml</i>	Preferred	AGE (Max 12 Years)
<i>sirolimus oral tablet 0.5 mg, 2 mg</i>	Preferred	
<i>tacrolimus oral capsule 0.5 mg</i>	Preferred	QL (2 EA per 1 day)
<i>tacrolimus oral capsule 1 mg</i>	Preferred	QL (8 EA per 1 day)
<i>tacrolimus oral capsule 5 mg</i>	Preferred	QL (4 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
*MAGNESIUM COMBINATIONS***		
BEELITH ORAL TABLET 362-20 MG (<i>magnesium oxide-pyridoxine hcl</i>)	Preferred	
SLOWMAG MG MUSCLE/HEART ORAL TABLET DELAYED RELEASE 71.5-119 MG (<i>magnesium cl-calcium carbonate</i>)	Preferred	
SLOW-MAG ORAL TABLET DELAYED RELEASE 71.5-119 MG (<i>magnesium cl-calcium carbonate</i>)	Preferred	
*MAGNESIUM***		
<i>magnesium lactate oral tablet extended release 84 mg (7meq)</i>	Preferred	
<i>magnesium oxide -mg supplement oral tablet 400 (240 mg) mg, 500 mg</i>	Preferred	
<i>sm magnesium oral tablet 250 mg</i>	Preferred	
<i>true magnesium oxide oral tablet 400 mg, 500 mg</i>	Preferred	
MAGNESIUM-OXIDE ORAL TABLET 400 (240 MG) MG (<i>magnesium oxide</i>)	Preferred	
MAGONATE ORAL LIQUID 54 (MAG EQUIV) MG/5ML (<i>magnesium carbonate</i>)	Preferred	
*MASKS***		
<i>breathe comfort protect shield</i>	Preferred	
<i>cvs medical face masks earloop</i>	Preferred	
<i>cvs procedural mask</i>	Preferred	
<i>disposable face mask</i>	Preferred	
<i>disposable face mask 3-ply</i>	Preferred	
<i>ear-loop mask small</i>	Preferred	
<i>face mask</i>	Preferred	
<i>face mask earloop-style</i>	Preferred	
<i>face mask resp n-100 part</i>	Preferred	
<i>face mask respirator r-95 part</i>	Preferred	
<i>face masks 3 layer non-medical</i>	Preferred	
<i>kn95 disposable mask</i>	Preferred	
<i>kn95 medical protective mask</i>	Preferred	
<i>mask pediatric size 1"</i>	Preferred	
<i>n95 face mask</i>	Preferred	
<i>n95 parti respirator face mask</i>	Preferred	
<i>pediatric medium mask</i>	Preferred	
<i>pediatric small mask</i>	Preferred	
<i>surgical face mask/niosh n95</i>	Preferred	
ACTEEV PROTECT FACE MASK (<i>masks</i>)	Preferred	
CLEVER CHOICE DISPOSABLE MASK (<i>masks</i>)	Preferred	
CLEVER CHOICE FACE MASK (<i>masks</i>)	Preferred	
EASY FLOW KN 95 (<i>masks</i>)	Preferred	
J & J GERM FILTER MASK (<i>masks</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
NEXCARE ALL PURPOSE MASK (<i>masks</i>)	Preferred	
NEXCARE EARLOOP MASK (<i>masks</i>)	Preferred	
SAFE-SENSE EARLOOP FACE MASK (<i>masks</i>)	Preferred	
SHIELD-SECURE FULL FACE SHIELD (<i>masks</i>)	Preferred	
*MEDICAL WASTE DISPOSAL SYSTEMS***		
<i>bd sharps container home</i>	Preferred	QL (1 EA per 1 day)
<i>cvs needle collection/disposal</i>	Preferred	QL (1 EA per 1 day)
<i>easy comfort sharps container</i>	Preferred	QL (1 EA per 1 day)
<i>sharps collector</i>	Preferred	QL (1 EA per 1 day)
<i>sharps container</i>	Preferred	QL (1 EA per 1 day)
<i>sharps disposal by mail system</i>	Preferred	QL (1 EA per 1 day)
BD PHLEBOTOMY SHARPS COLLECTOR (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
BD SHARPS COLLECTOR (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
COMPLETE NEEDLE COLLECTION SYS (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
MONOJECT SHARPS CONTAINER (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
ULTILET SHARPS CONTAINER 1QT (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
ULTILET SHARPS CONTAINER 2QT (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
VERIFINE SHARPS CONTAINER (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
*MINERALOCORTICOID***		
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	Preferred	
*MISC. ANTI-ULCER***		
<i>sucralfate oral suspension 1 gm/10ml</i>	Preferred	
<i>sucralfate oral tablet 1 gm</i>	Preferred	
*MISC. NUTRITIONAL SUBSTANCES***		
<i>fish oil high potency oral capsule 1000 mg</i>	Preferred	
<i>fish oil oral capsule 1000 mg, 500 mg</i>	Preferred	
<i>sm fish oil oral capsule 1000 mg</i>	Preferred	
<i>sm omega-3 fish oil oral capsule 1200 mg</i>	Preferred	
SEA-OMEGA ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
*MISC. RESPIRATORY INHALANTS***		
<i>sodium chloride inhalation nebulization solution 0.9 %</i>	Preferred	
*MISC. TOPICAL COMBINATIONS***		
<i>calamine external lotion 8-8 %</i>	Preferred	
<i>gnp calamine external lotion 8-8 %</i>	Preferred	
<i>sm calamine external lotion</i>	Preferred	
*MISC. TOPICAL***		
<i>hemorrhoidal external pad 50 %</i>	Preferred	
<i>hm medicated cooling external pad 50 %</i>	Preferred	
<i>medi-pads external pad 50 %</i>	Preferred	
<i>sm medicated wipes external pad 50 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*MITOTIC INHIBITORS***		
<i>etoposide oral capsule 50 mg</i>	Preferred	
*MIXED ADRENERGICS***		
ASTHMANEFRIN REFILL INHALATION NEBULIZATION SOLUTION 2.25 % (<i>racepinephrine hcl</i>)	Preferred	
S2 (RACEPINEPHRINE) INHALATION NEBULIZATION SOLUTION 2.25 % (<i>racepinephrine hcl</i>)	Preferred	
*MUCOLYTICS***		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	Preferred	
*MULTIPLE VITAMINS W/ IRON***		
<i>sm multiple vitamins/iron oral tablet</i>	Preferred	
*MULTIPLE VITAMINS W/ MINERALS***		
<i>dialyvite 800/ultra d oral tablet</i>	Preferred	
<i>glucoten oral capsule</i>	Preferred	
<i>gnp healthy eyes oral tablet</i>	Preferred	
<i>gnp mega multi for men oral tablet</i>	Preferred	
<i>gnp mega multi for women oral tablet</i>	Preferred	
<i>gnp one daily mens health 50+ oral tablet</i>	Preferred	
<i>gnp one daily mens/lycopene oral tablet</i>	Preferred	
<i>gnp one daily womens 50+ oral tablet</i>	Preferred	
<i>gnp one daily womens oral tablet</i>	Preferred	
<i>i-vite oral tablet</i>	Preferred	
<i>multiple vitamins-minerals oral liquid</i>	Preferred	
<i>multivit/multimineral adult oral liquid</i>	Preferred	
<i>sm complete advanced formula oral tablet</i>	Preferred	
<i>sm complete oral tablet</i>	Preferred	
<i>sm complete senior formula oral tablet</i>	Preferred	
<i>sm daily diet support oral tablet</i>	Preferred	
<i>sm opti-vitamins oral tablet</i>	Preferred	
<i>v-c forte oral capsule</i>	Preferred	
CEROVITE SENIOR ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CERTAVITE/ANTIOXIDANTS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
COMPETE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ICAPS LUTEIN & OMEGA-3 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
ICAPS MV ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ICAPS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multiple vitamins-minerals</i> (Nutrifac Zx Oral Tablet)	Preferred	
OCUVITE EXTRA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
OCUVITE EYE + MULTI ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE EYE HEALTH FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE EYE HEALTH GUMMIES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE-LUTEIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION AREDS 2 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
PROSIGHT ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
RENAPLEX ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
SYSTANE ICAPS AREDS2 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
SYSTANE ICAPS AREDS2 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multiple vitamins-minerals</i> (Vita S Forte Oral Tablet)	Preferred	
*MULTIVITAMINS***		
<i>daily-vite oral tablet</i>	Preferred	
<i>gnp essential one daily oral tablet</i>	Preferred	
<i>sm multiple vitamins essential oral tablet</i>	Preferred	
<i>stress formula oral tablet</i>	Preferred	
<i>true daily vite oral tablet</i>	Preferred	
TAB-A-VITE/BETA CAROTENE ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
*NASAL AGENTS - MISC.***		
<i>deep sea nasal spray nasal solution 0.65 %</i>	Preferred	
<i>saline mist spray nasal solution 0.65 %</i>	Preferred	
<i>saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>sm nasal spray saline nasal solution 0.65 %</i>	Preferred	
<i>true nasal moisturizing nasal solution 0.65 %</i>	Preferred	
AFRIN SALINE NASAL MIST NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
OCEAN FOR KIDS NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
*NASAL MAST CELL STABILIZERS***		
<i>cromolyn sodium nasal aerosol solution 5.2 mg/act</i>	Preferred	
*NATURAL PENICILLINS***		
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	Preferred	
*NEEDLES & SYRINGES***		
<i>1st tier unifine pentips 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>1st tier unifine pentips plus 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
<i>aum mini insulin pen needle 32g x 5 mm , 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>aum pen needle 32g x 5 mm , 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>careone unifine pentips plus 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>carepoint poly hub needle 18g x 1" , 18g x 1-1/2" , 20g x 1" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"</i>	Preferred	
<i>carepoint poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"</i>	Preferred	90-day fill allowed after two 1-month fills
<i>carepoint safety 1st needle 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"</i>	Preferred	
<i>carepoint safety 1st needle 25g x 5/8"</i>	Preferred	90-day fill allowed after two 1-month fills
<i>carepoint syringe luer lock 1 ml</i>	Preferred	
<i>carepoint syringe luer slip 1 ml</i>	Preferred	
<i>carepoint tubercln syr/luer sl 25g x 5/8" 1 ml</i>	Preferred	
<i>easy comfort pen needles 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>easy glide pen needles 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>easy glide slip lock syringe 1 ml</i>	Preferred	
<i>hypodermic needle 18g x 1" , 18g x 1-1/2" , 20g x 1" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1-1/2" , 27g x 1-1/2"</i>	Preferred	
<i>hypodermic needle 25g x 5/8" , 27g x 1/2"</i>	Preferred	90-day fill allowed after two 1-month fills
<i>insulin syringe-needle u-100 31g x 1/4" 0.3 ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>kmart valu insulin syringe 29g u-100 1 ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>kmart valu insulin syringe 30g u-100 1 ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>kroger pen needles 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>pen needles 30g x 5 mm , 30g x 8 mm , 32g x 5 mm , 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>poly hub needle 18g x 1" , 18g x 1-1/2" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"</i>	Preferred	
<i>poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"</i>	Preferred	90-day fill allowed after two 1-month fills
<i>pro comfort pen needles 32g x 5 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>pure comfort pen needle 32g x 5 mm</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>safety pen needles 30g x 5 mm , 30g x 8 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sure comfort insulin syringe 31g x 1/4" 0.3 ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sure comfort pen needles 30g x 8 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>syringe luer lock 20g x 1" 10 ml, 20g x 1" 3 ml, 21g x 1" 3 ml, 21g x 1-1/2" 3 ml, 22g x 1" 3 ml, 22g x 1-1/2" 3 ml, 23g x 1" 3 ml, 23g x 1-1/2" 3 ml, 25g x 1" 3 ml, 25g x 1-1/2" 3 ml, 25g x 5/8" 3 ml</i>	Preferred	
<i>syringe luer slip 1 ml</i>	Preferred	
<i>techlite insulin syringe 29g x 1/2" 0.3 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 30g x 1/2" 0.3 ml, 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 15/64" 0.3 ml, 31g x 15/64" 0.5 ml, 31g x 15/64" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>true comfort pro pen needles 32g x 5 mm , 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ultracare pen needles 32g x 5 mm , 33g x 4 mm</i>	Preferred	90-day fill allowed after two 1-month fills
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
BD ALLERGY SYRINGE 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
BD AUTOSHIELD DUO 30G X 5 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
BD BLUNT FILL NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD BLUNT FILTER NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD DISP NEEDLE 23G X 1" , 25G X 1" (<i>needle (disp)</i>)	Preferred	
BD DISP NEEDLES 18G X 1-1/2" , 20G X 1" , 22G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD DISP NEEDLES 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD ECLIPSE NEEDLE 25G X 5/8" , 27G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
BD ECLIPSE SHIELDED NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
BD ECLIPSE SYRINGE 21G X 1" 3 ML, 25G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD ECLIPSE SYRINGE/NEEDLE 22G X 1" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD FILTER NEEDLE/5 MICRON (<i>needles & syringes</i>)	Preferred	
BD HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	90-day fill allowed after two 1-month fills
BD INSULIN SYRINGE U-100 1 ML (<i>insulin syringes (disposable)</i>)	Preferred	90-day fill allowed after two 1-month fills
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (<i>insulin syringe/needle u-500</i>)	Preferred	90-day fill allowed after two 1-month fills
BD INTEGRA NEEDLE 23G X 1" (<i>needle (disp)</i>)	Preferred	
BD INTEGRA SYRINGE 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD LUER-LOCK SYRINGE 18G X 1-1/2" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML, 20G X 1" 1 ML, 20G X 1" 10 ML, 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1" 5 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD NOKOR ADMIX NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD PLASTIPAK SYRINGE 21G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD PRECISIONGLIDE NEEDLE 23G X 1-1/2" , 27G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD SAFETYGLIDE ALLERGY SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
BD SAFETYGLIDE NEEDLE 18G X 1-1/2" , 25G X 1" (<i>needle (disp)</i>)	Preferred	
BD SAFETYGLIDE NEEDLE 21G X 1-1/2" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD SAFETYGLIDE NEEDLE 25G X 5/8" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
BD SAFETYGLIDE SHIELDED NEEDLE 22G X 1-1/2" , 23G X 1" (<i>needle (disp)</i>)	Preferred	
BD SAFETYGLIDE SYRINGE/NEEDLE 25G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD SYRINGE LUER-LOK 1 ML (<i>syringe (disposable)</i>)	Preferred	
BD SYRINGE SLIP TIP 1 ML (<i>syringe (disposable)</i>)	Preferred	
BD SYRINGE SLIP TIP 25G X 5/8" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD TB SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
CAREFINE PEN NEEDLES 30G X 8 MM , 32G X 5 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
CAREPOINT SAFETY1ST SYR/NEEDLE 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
CAREPOINT SYRINGE LUER LOCK 20G X 1" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
CARETOUCH HYPODERMIC NEEDLE 18G X 1-1/2" , 20G X 1" , 22G X 1" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
CARETOUCH HYPODERMIC NEEDLE 25G X 5/8" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
CARETOUCH LUER LOCK 1 ML (<i>syringe (disposable)</i>)	Preferred	
CARETOUCH LUER LOCK 23G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
CARETOUCH LUER LOCK SYR/NEEDLE 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
CARETOUCH LUER SLIP 1 ML (<i>syringe (disposable)</i>)	Preferred	
CARETOUCH PEN NEEDLES 32G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
CLEVER CHOICE COMFORT EZ 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
COMFORT EZ PEN NEEDLES 32G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
DROPLET PEN NEEDLES 30G X 8 MM , 32G X 5 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
DROPSAFE SICURA 25G X 1" (<i>needle (disp)</i>)	Preferred	
EASY GLIDE LUER LOCK SYRINGE 1 ML (<i>syringe (disposable)</i>)	Preferred	
EASY TOUCH ALLERGY SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
EASY TOUCH FLIPLOCK SAFETY SYR 18G X 1-1/2" 3 ML, 20G X 1" 10 ML, 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
EASY TOUCH HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
EASY TOUCH HYPODERMIC NEEDLE 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 32G X 5 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM , 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH SAFETY SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
EASY TOUCH SYRINGE BARREL 10ML (<i>needles & syringes</i>)	Preferred	
EASY TOUCH SYRINGE BARREL 1ML (<i>needles & syringes</i>)	Preferred	
EASY TOUCH SYRINGE BARREL 3ML (<i>needles & syringes</i>)	Preferred	
EASY TOUCH SYRINGE BARREL 5ML (<i>needles & syringes</i>)	Preferred	
EASY TOUCH TB FLIPLOCK SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
EASY TOUCH TB SHEATHLOCK SYR 25G X 5/8" 1 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
EASYPOINT NEEDLE 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
EASYPOINT NEEDLE 25G X 5/8" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
EASYPOINT NEEDLE/SYRINGE 18G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
H-E-B INCONTROL UNIFINE PENTIP 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
LUER LOCK SAFETY SYRINGES 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
MAGELLAN TUBERCULIN SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
MICRODOT PEN NEEDLE 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT FILTER ASPIRATOR (<i>needles & syringes</i>)	Preferred	
MONOJECT HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
MONOJECT HYPODERMIC NEEDLE 25G X 5/8" , 27G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT INSULIN SYRINGE U-100 1 ML (<i>insulin syringes (disposable)</i>)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT MAGELLAN SAFETY NDL 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" (<i>needle (disp)</i>)	Preferred	
MONOJECT MAGELLAN SAFETY NDL 25G X 5/8" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT MAGELLAN SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
MONOJECT PHARMACY TRAY 1 ML (<i>syringe (disposable)</i>)	Preferred	
MONOJECT SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML, 27G X 1-1/4" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
MONOJECT SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
MONOJECT SYRINGE PHARMACY TRAY 1 ML (<i>syringe (disposable)</i>)	Preferred	
MONOJECT TB SAFETY SYRINGE 25G X 5/8" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
MONOJECT TB SYRINGE 1 ML (<i>syringe (disposable)</i>)	Preferred	
MONOJECT TB SYRINGE 25G X 5/8" 1 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
NOKOR VENTED NEEDLE 18G X 1" (<i>needle (disp)</i>)	Preferred	
NORM-JECT LUER SLIP SYRINGE 1 ML (<i>syringe (disposable)</i>)	Preferred	
PERFECT POINT SAFETY NEEDLE 25G X 1" (<i>needle (disp)</i>)	Preferred	
SECURESAFE HYPODERMIC NEEDLE 22G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
SECURESAFE HYPODERMIC NEEDLE 27G X 1/2" (<i>needle (disp)</i>)	Preferred	90-day fill allowed after two 1-month fills
SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
SECURESAFE SYRINGE/NEEDLE 20G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
TECHLITE PEN NEEDLES 29G X 10MM , 29G X 12MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM , 32G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	90-day fill allowed after two 1-month fills
TRUEPLUS PEN NEEDLES 29G X 12MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE MINI PEN NEEDLES 30G X 5 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE SHORT PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE SYRINGE 22G X 1-1/2" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
ULTICARE TUBERCULIN SAFETY SYR 25G X 1" 1 ML, 25G X 5/8" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE PENTIPS 30G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE PENTIPS PLUS 30G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM , 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	90-day fill allowed after two 1-month fills
VANISHPOINT SAFETY SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
VANISHPOINT SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
VANISHPOINT TUBERCULIN SYRINGE 25G X 1" 1 ML, 25G X 5/8" 1 ML, 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
*NIT REMOVERS***		
LYCELLE EXTERNAL GEL (<i>nit remover</i>)	Preferred	
*NITRATES***		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	Preferred	QL (12 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg</i>	Preferred	QL (6 EA per 1 day)
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr</i>	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
NITRO-BID TRANSDERMAL OINTMENT 2 % (<i>nitroglycerin</i>)	Preferred	QL (4 GM per 1 day); 90-day fill allowed after two 1-month fills
*NITROGEN MUSTARDS AND RELATED ANALOGUES***		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	Preferred	SP; PA
*NON-NARC ANTITUSSIVE-ANTI HISTAMINE***		
<i>cough & cold hbp oral tablet 4-30 mg</i>	Preferred	
<i>cough & cold oral tablet 4-30 mg</i>	Preferred	
<i>dextromethorphan-pyrimidine oral liquid 7.5-7.5 mg/5ml</i>	Preferred	
<i>gnp cough & cold hbp oral tablet 4-30 mg</i>	Preferred	
<i>gnp night time cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>goodsense night time cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>sm cough/runny nose childrens oral liquid 1-5 mg/5ml</i>	Preferred	
CORICIDIN HBP COUGH/COLD ORAL TABLET 4-30 MG (<i>chlorpheniramine-dm</i>)	Preferred	
*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTI HISTAMINE***		
<i>cold & cough childrens oral liquid 1-5-2.5 mg/5ml</i>	Preferred	
<i>cold/cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>ed-a-hist dm oral liquid 10-4-15 mg/5ml</i>	Preferred	
<i>ft cold & cough relief dm oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>gnp cold/cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>hm cold & cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>lohist-dm oral syrup 5-2-10 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>nohist-dm oral liquid 10-4-15 mg/5ml</i>	Preferred	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>rynex dm oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>sm cold & cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
DIMAPHEN DM COLD/COUGH ORAL LIQUID 2.5-1-5 MG/5ML (<i>phenylephrine-bromphen-dm</i>)	Preferred	
ENDACOF-DM ORAL LIQUID 2.5-1-5 MG/5ML (<i>phenylephrine-bromphen-dm</i>)	Preferred	
*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTI-HISTAMINE-ANALG***		
<i>ft cold & flu nighttime severe oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>goodsense nighttime cold & flu oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>sm cold head congestion night oral tablet 5-2-10-325 mg</i>	Preferred	
<i>sm nite time cold & flu oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)***		
<i>sm ibuprofen jr oral tablet 100 mg</i>	Preferred	
*NUTRITIONAL SUPPLEMENTS***		
<i>thrivacin 30 oral liquid</i>	Preferred	
<i>thrivacin detox oral liquid</i>	Preferred	
SM NUTRI-DRINK + ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
SM NUTRI-DRINK ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
*OPHTHALMIC DECONGESTANT COMBINATIONS***		
<i>gnp eye drops ophthalmic solution 0.05-0.25 %</i>	Preferred	
*OPHTHALMIC DECONGESTANTS***		
<i>eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>ft eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>gnp eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>sm eye drops ophthalmic solution 0.05 %</i>	Preferred	
*OPHTHALMIC HYPEROSMOLAR PRODUCTS***		
<i>sodium chloride (hypertonic) ophthalmic ointment 5 %</i>	Preferred	
<i>sodium chloride (hypertonic) ophthalmic solution 5 %</i>	Preferred	
MURO 128 OPHTHALMIC SOLUTION 2 % (<i>sodium chloride (hypertonic)</i>)	Preferred	
*OPHTHALMIC IRRIGATION SOLUTIONS***		
<i>eye wash ophthalmic solution</i>	Preferred	
<i>sm eye wash ophthalmic solution 0.002 %</i>	Preferred	
EYE STREAM OPHTHALMIC SOLUTION (<i>ophth irr soln-extraocular</i>)	Preferred	

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*OPHTHALMIC LOCAL ANESTHETICS***		
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	Preferred	
*OPIOID ANTITUSSIVE-DECONGESTANT-ANTI-HISTAMINE***		
<i>capcof oral syrup 5-2-10 mg/5ml</i>	Preferred	
*ORAL VEHICLES***		
<i>simple syrup oral syrup</i>	Preferred	
<i>sorbitol solution , 70 %</i>	Preferred	
MX-SOL BLEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
MX-SOL BLEND SF ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
MX-SOL ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
MX-SOL SF ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
MX-SOL SUSPEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORA-BLEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORA-BLEND SF ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORA-PLUS ORAL LIQUID (<i>oral vehicles</i>)	Preferred	
ORA-SWEET ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
ORA-SWEET SF ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
SOSWEET ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
*OTIC AGENTS - MISCELLANEOUS***		
<i>acetic acid otic solution 2 %</i>	Preferred	
<i>ear drops otic solution 6.5 %</i>	Preferred	
<i>earwax removal otic solution 6.5 %</i>	Preferred	
<i>ft earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>ft earwax removal otic solution 6.5 %</i>	Preferred	
<i>gnp earwax removal drops otic solution 6.5 %</i>	Preferred	
<i>gnp earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>sm ear drops otic solution 6.5 %</i>	Preferred	
*OTIC STEROIDS***		
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	Preferred	
*OXAZOLIDINONES***		
<i>linezolid oral tablet 600 mg</i>	Preferred	QL (2 EA per 1 day)
*OXYTOCICS***		
<i>methylergonovine maleate oral tablet 0.2 mg</i>	Preferred	QL (6 EA per 1 day)
<i>methylergonovine maleate (Methergine Oral Tablet 0.2 Mg)</i>	Preferred	QL (6 EA per 1 day)
*PARENTERAL VEHICLES***		
<i>sterile water for injection injection solution</i>	Preferred	
*PEAK FLOW METERS***		
<i>breathe ease peak flow meter device</i>	Preferred	
<i>lung perform peak flow meter device</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>peak a-i-r flow meter device</i>	Preferred	
<i>peak flow meter universal rang device</i>	Preferred	
<i>pure comfort flow meter adult device</i>	Preferred	
<i>pure comfort flow meter child device</i>	Preferred	
AIRZONE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
ASSESS PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
CLEVER CHOICE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
MICROLIFE DIGITAL PEAK FLOW DEVICE (<i>peak flow meter</i>)	Preferred	
MINI WRIGHT PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
PEAK AIR PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
PERSONAL BEST FULL RANGE DEVICE (<i>peak flow meter</i>)	Preferred	
PIKO 1 DEVICE (<i>peak flow meter</i>)	Preferred	
POCKET PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
POCKETPEAK PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
STRIVE DUAL ZONE PEAK FLOW MTR DEVICE (<i>peak flow meter</i>)	Preferred	
TRUZONE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
*PED MV W/ FLUORIDE***		
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	
<i>multivitamin/fluoride oral solution 0.25 mg/ml</i>	Preferred	
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml</i>	Preferred	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	
FLORAFOL PEDIATRIC ORAL TABLET CHEWABLE 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (<i>pediatric multivitamins-fl</i>)	Preferred	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML (<i>pediatric multivitamins-fl</i>)	Preferred	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	
SOLUVITA WITH FLUORIDE ORAL SOLUTION 0.25 MG/ML (<i>pediatric multivitamins-fl</i>)	Preferred	
*PED MV W/ IRON***		
<i>gnp childrens chewables/iron oral tablet chewable 15 mg</i>	Preferred	
<i>multivitamin infant & toddler oral solution 11 mg/ml</i>	Preferred	
<i>sm animal shapes complete oral tablet chewable 18 mg</i>	Preferred	

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CEROVITE JR ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
*PEDIATRIC MULTIPLE VITAMINS***		
<i>gnp childrens chewables/ex c oral tablet chewable</i>	Preferred	
<i>gnp little ones childrens oral tablet chewable</i>	Preferred	
<i>multivitamin infant & toddler oral solution</i>	Preferred	
<i>sm animal shapes kids first oral tablet chewable</i>	Preferred	
*PENICILLIN COMBINATIONS***		
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	Preferred	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	Preferred	
<i>amoxicillin-pot clavulanate oral tablet chewable 400-57 mg</i>	Preferred	
*PENICILLINASE-RESISTANT PENICILLINS***		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	Preferred	
*PHOSPHATE***		
<i>phosphorous oral tablet 155-852-130 mg</i>	Preferred	
<i>phosphorus supplement oral packet 280-160-250 mg</i>	Preferred	
<i>wes-phos 250 neutral oral tablet 155-852-130 mg</i>	Preferred	
<i>k phos mono-sod phos di & mono (Phospha 250 Neutral Oral Tablet 155-852-130 Mg)</i>	Preferred	
<i>k phos mono-sod phos di & mono (Phospho-Trin 250 Neutral Oral Tablet 155-852-130 Mg)</i>	Preferred	
<i>potassium phosphate monobasic (Phospho-Trin K500 Oral Tablet 500 Mg)</i>	Preferred	
*PHOSPHODIESTERASE III INHIBITORS***		
<i>cilostazol oral tablet 100 mg, 50 mg</i>	Preferred	QL (2 EA per 1 day)
*POTASSIUM REMOVING AGENTS***		
<i>sodium polystyrene sulfonate oral powder</i>	Preferred	
*POTASSIUM SPARING DIURETICS***		
<i>amiloride hcl oral tablet 5 mg</i>	Preferred	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
*POTASSIUM***		
<i>potassium chloride crys er oral tablet extended release 10 meq</i>	Preferred	
<i>potassium chloride crys er oral tablet extended release 20 meq</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium chloride er oral tablet extended release 10 meq, 8 meq</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium chloride er oral tablet extended release 20 meq</i>	Preferred	
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%)</i>	Preferred	

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<i>potassium chloride oral solution 40 meq/15ml (20%)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium bicarbonate (Effer-K Oral Tablet Effervescent 25 Meq)</i>	Preferred	
<i>potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)</i>	Preferred	
<i>potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium chloride (Klor-Con Oral Tablet Extended Release 8 Meq)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>potassium bicarbonate (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)</i>	Preferred	
*PRENATAL MV & MIN W/FE-FA***		
<i>classic prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>completenate oral tablet chewable 29-1 mg</i>	Preferred	
<i>gnp prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>m-natal plus oral tablet 27-1 mg</i>	Preferred	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg</i>	Preferred	
<i>prenatal plus oral tablet 27-1 mg</i>	Preferred	
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	Preferred	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>se-natal 19 oral tablet 29-1 mg</i>	Preferred	
<i>se-natal 19 oral tablet chewable 29-1 mg</i>	Preferred	
<i>sm prenatal vitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>thrivite rx oral tablet 29-1 mg</i>	Preferred	
<i>trinatal rx 1 oral tablet 60-1 mg</i>	Preferred	
<i>westab plus oral tablet 27-1 mg</i>	Preferred	
NIVA-PLUS ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
PRENATRIX ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
PRENATRYL ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
TRICARE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
VITAFOL-OB ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
*PRENATAL MV & MIN W/FE-FA-DHA***		
STUART ONE ORAL CAPSULE 27-0.8-200 MG (<i>prenatal mv-min-fe cbn-fa-dha</i>)	Preferred	
*PROGESTIN CONTRACEPTIVES - ORAL***		
<i>norethindrone oral tablet 0.35 mg</i>	Preferred	Max 365-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norethindrone</i> (Camila Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Deblitane Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Emzahh Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Errin Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Heather Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Incassia Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Jencycla Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Lyleq Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Lyza Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Nora-Be Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Norlyroc Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
<i>norethindrone</i> (Sharobel Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
*PSEUDOBULBAR AFFECT AGENT COMBINATIONS***		
NUEDEXTA ORAL CAPSULE 20-10 MG (<i>dextromethorphan-quinidine</i>)	Preferred	PA
*PURINE ANALOGS***		
<i>azathioprine oral tablet 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
*PYRIMIDINE SYNTHESIS INHIBITORS***		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	Preferred	
*QUATERNARY ANTICHOLINERGICS***		
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Preferred	
*RECTAL ANESTHETIC COMBINATIONS***		
<i>hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
*RECTAL COMBINATIONS - MISC.***		
<i>ft hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>gnp hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>goodsense hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>goodsense hemorrhoidal rectal suppository 0.25-88.44 %</i>	Preferred	
<i>hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>hemorrhoidal rectal suppository 0.25-88.44 %</i>	Preferred	
<i>sm hemorrhoidal cooling external gel 0.25-50 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
*RECTAL LOCAL ANESTHETICS***		
<i>gnp anorectal external cream 5 %</i>	Preferred	
<i>lidocaine (anorectal) external cream 5 %</i>	Preferred	
<i>numbcream external cream 5 %</i>	Preferred	
<i>pramoxine hcl (perianal) external foam 1 %</i>	Preferred	
RECTASMOOTH EXTERNAL CREAM 5 % (<i>lidocaine (anorectal)</i>)	Preferred	
*RESPIRATORY THERAPY SUPPLIES***		
<i>adult aerosol mask</i>	Preferred	
<i>adult disposable mouthpiece</i>	Preferred	
<i>adult mask device</i>	Preferred	
<i>adult mask large</i>	Preferred	
<i>breathe ease neb mask/child</i>	Preferred	
<i>breathe ease neb mask/infant</i>	Preferred	
<i>co monitor device</i>	Preferred	
<i>co monitor replacement pieces</i>	Preferred	
<i>disposable full range mouthpiece</i>	Preferred	
<i>disposable low range mouthpiece</i>	Preferred	
<i>disposable low range/pediatric mouthpiece</i>	Preferred	
<i>disposable paper mouthpiece</i>	Preferred	
<i>disposable universal range mouthpiece</i>	Preferred	
<i>expiratory mouthpiece</i>	Preferred	
<i>filter air pp</i>	Preferred	
<i>full kit nebulizer set</i>	Preferred	
<i>nebulizer air tube/plugs</i>	Preferred	
<i>nebulizer cup/tubing device</i>	Preferred	
<i>nebulizer mask adult</i>	Preferred	
<i>nebulizer mask child</i>	Preferred	
<i>nose clip</i>	Preferred	
<i>one-way valved expiratory mouthpiece</i>	Preferred	
<i>one-way valved inspiratory mouthpiece</i>	Preferred	
<i>ped disposable mouthpiece</i>	Preferred	
<i>pediatric mouthpiece</i>	Preferred	
<i>pharmacist choice mask wipes</i>	Preferred	
<i>pillow mask/adult</i>	Preferred	
<i>pillow mask/child</i>	Preferred	
<i>pillow mask/pediatric</i>	Preferred	
<i>pure comfort 3-ball breathe ex device</i>	Preferred	
<i>replacement air filter</i>	Preferred	
<i>replacement filters</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>silicone mask/adult</i>	Preferred	
<i>silicone mask/infant</i>	Preferred	
<i>silicone mask/pediatric</i>	Preferred	
<i>sootheneb nbl 100 adult mask</i>	Preferred	
<i>sootheneb nbl 100 child mask</i>	Preferred	
<i>sootheneb nbl 100 med cup</i>	Preferred	
<i>sootheneb nbl 100 mesh cap</i>	Preferred	
<i>spiro pd device</i>	Preferred	
<i>tubing/wing tip</i>	Preferred	
<i>ultra neb accessories kit</i>	Preferred	
ACE AEROSOL CLOUD ENHANCER (<i>respiratory therapy supplies</i>)	Preferred	
ACTIVITY POUCH (<i>respiratory therapy supplies</i>)	Preferred	
ADAPTER PED DISPOSABLE MOUTHPIECE (<i>respiratory therapy supplies</i>)	Preferred	
AEROBIKA DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
AEROECLIPSE EZ TWIST TUBING (<i>respiratory therapy supplies</i>)	Preferred	
AEROECLIPSE MASK LARGE (<i>respiratory therapy supplies</i>)	Preferred	
AEROECLIPSE MASK MEDIUM (<i>respiratory therapy supplies</i>)	Preferred	
AEROECLIPSE MASK SMALL (<i>respiratory therapy supplies</i>)	Preferred	
AEROTRACH PLUS (<i>respiratory therapy supplies</i>)	Preferred	
AIRS PEDIATRIC AEROSOL MASK (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 1000 PFT FILTER (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 1000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 2000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 3000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 4000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 5000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 6000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 7000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
BUBBLES THE FISH II PEDI MASK (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH 2 CPAP HOSE HANGER (<i>respiratory therapy supplies</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
CARETOUCH CPAP & BIPAP HOSE (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP MASK WIPES (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP PRE-WASH SOLN (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP TUBE BRUSH (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH UNIVERSL CPAP FILTER (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW 300 MM HOSE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW 400 MM HOSE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW AIR NOZZLE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/BLUE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/ORANGE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/RED DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/WHITE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/YELLOW DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW HEPA FILTER (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/BLUE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/GREEN DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/PINK DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/WHITE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/YELLOW DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EBASE CONTROLLER KIT (<i>respiratory therapy supplies</i>)	Preferred	
FLYP HYPERSONIQ CARTRIDGE (<i>respiratory therapy supplies</i>)	Preferred	
IN-CHECK DIAL FLOW TRAINER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
IN-CHECK INSPIRATORY FLOW MTR DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
INNOSPIRE REPLACEMENT FILTER (<i>respiratory therapy supplies</i>)	Preferred	
KOKO PEAK PRO MOUTHPIECE (<i>respiratory therapy supplies</i>)	Preferred	
LITETOUCH MASK LARGE (<i>respiratory therapy supplies</i>)	Preferred	
LITETOUCH MASK MEDIUM (<i>respiratory therapy supplies</i>)	Preferred	
LITETOUCH MASK SMALL (<i>respiratory therapy supplies</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
MINIELITE FILTER REPLACEMENTS (<i>respiratory therapy supplies</i>)	Preferred	
OMBRA COMPRESSOR AIR FILTERS (<i>respiratory therapy supplies</i>)	Preferred	
OMBRA TABLE TOP COMPRESSOR DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ONE FLOW SPIROMETER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ONE FLOW TESTER MOUTHPIECE (<i>respiratory therapy supplies</i>)	Preferred	
PARI ALTERA NEBULIZER HANDSET (<i>respiratory therapy supplies</i>)	Preferred	
PARI BABY CONVERSION KIT (<i>respiratory therapy supplies</i>)	Preferred	
PARI BUBBLES PEDIATRIC MASK (<i>respiratory therapy supplies</i>)	Preferred	
PARI ERAPID NEBULIZER HANDSET (<i>respiratory therapy supplies</i>)	Preferred	
PARI EXPIRATORY FILTER SET DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
PARI MANUAL INTERRUPTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
PARI MASK SET (<i>respiratory therapy supplies</i>)	Preferred	
PARI SMARTMASK BABY/ELBOW (<i>respiratory therapy supplies</i>)	Preferred	
PARI SOFT PLASTIC ADULT MASK (<i>respiratory therapy supplies</i>)	Preferred	
PARI SOFT PLASTIC PED MASK (<i>respiratory therapy supplies</i>)	Preferred	
PARI TREK S COMBO PACK DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
PFLEX (<i>respiratory therapy supplies</i>)	Preferred	
PRONEB ULTRA FILTER SET (<i>respiratory therapy supplies</i>)	Preferred	
QUAKE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
REUSABLE COMFORTSEAL MASK-LRG (<i>respiratory therapy supplies</i>)	Preferred	
REUSABLE COMFORTSEAL MASK-MED (<i>respiratory therapy supplies</i>)	Preferred	
REUSABLE COMFORTSEAL MASK-SML (<i>respiratory therapy supplies</i>)	Preferred	
SAMI THE SEAL FILTERS (<i>respiratory therapy supplies</i>)	Preferred	
SIDESTREAM ADULT FACE MASK (<i>respiratory therapy supplies</i>)	Preferred	
SIDESTREAM PEDIATRIC FACE MASK (<i>respiratory therapy supplies</i>)	Preferred	
SIDESTREAM PLS ADULT FACE MASK (<i>respiratory therapy supplies</i>)	Preferred	
THRESHOLD IMT (<i>respiratory therapy supplies</i>)	Preferred	
THRESHOLD PEP DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
VERSAPAP DEVICE (<i>respiratory therapy supplies</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
VERSAPAP W/UNIVERSAL TUBING DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
WINDMILL TRAINER (<i>respiratory therapy supplies</i>)	Preferred	
*RETINOIDS***		
<i>tretinoin oral capsule 10 mg</i>	Preferred	PA; QL (90 EA per 365 days)
*SALICYLATE COMBINATIONS***		
<i>effervescent antacid/pain rel oral tablet effervescent 500 mg</i>	Preferred	
<i>sm aspirin tri-buffered oral tablet 325 mg</i>	Preferred	
<i>sm effervescent pain relief oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>tri-buffered aspirin oral tablet 325 mg</i>	Preferred	
*SALICYLATES***		
<i>aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>aspirin oral tablet 325 mg</i>	Preferred	
<i>aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>aspirin oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>aspirin rectal suppository 300 mg</i>	Preferred	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ft aspirin oral tablet 325 mg</i>	Preferred	
<i>ft aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>ft enteric coated aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	Preferred	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>gnp aspirin oral tablet 325 mg</i>	Preferred	
<i>gnp aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense aspirin adults oral tablet 325 mg</i>	Preferred	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>goodsense aspirin oral tablet 325 mg</i>	Preferred	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>hm adult aspirin oral tablet 325 mg</i>	Preferred	
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
<i>sm aspirin ec low strength oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	Preferred	
*SALINE LAXATIVE MIXTURES***		
<i>enema ready-to-use rectal enema 7-19 gm/118ml</i>	Preferred	
<i>enema rectal enema 7-19 gm/118ml</i>	Preferred	
<i>ft enema saline rectal enema 7-19 gm/118ml</i>	Preferred	
<i>hm enema rectal enema 7-19 gm/118ml</i>	Preferred	
<i>sm enema rectal enema , 7-19 gm/118ml</i>	Preferred	
*SALINE LAXATIVES***		
<i>cvs epsom salt granules</i>	Preferred	
<i>epsom salt granules</i>	Preferred	
<i>epsom salt oral granules</i>	Preferred	
<i>eql epsom salt granules</i>	Preferred	
<i>ft epsom salt oral granules</i>	Preferred	
<i>ft magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>ft milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>gnp epsom salt oral granules</i>	Preferred	
<i>gnp magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>gnp milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>hm milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>milk of magnesia concentrate oral suspension 2400 mg/10ml</i>	Preferred	
<i>milk of magnesia oral suspension 1200 mg/15ml, 2400 mg/30ml, 400 mg/5ml, 7.75 %</i>	Preferred	
<i>ra epsom salt granules</i>	Preferred	
<i>sm epsom salt oral granules</i>	Preferred	
<i>sm milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>PEDIA-LAX ORAL TABLET CHEWABLE 400 MG (magnesium hydroxide)</i>	Preferred	
*SCABICIDE COMBINATIONS***		
<i>ft lice killing max st external shampoo 0.33-4 %</i>	Preferred	
<i>gnp lice killing external shampoo 0.33-4 %</i>	Preferred	
<i>gnp lice treatment external shampoo 0.33-4 %</i>	Preferred	
<i>lice killing external shampoo 0.33-4 %</i>	Preferred	
<i>lice killing maximum strength external shampoo 0.33-4 %</i>	Preferred	
<i>lice killing shampoo max str external shampoo 0.33-4 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm lice killing external shampoo 0.33-4 %</i>	Preferred	
<i>sm lice killing max strength external shampoo 0.33-4 %</i>	Preferred	
*SCABICIDES & PEDICULICIDES***		
<i>gnp lice treatment external liquid 1 %</i>	Preferred	
<i>goodsense lice killing external liquid 1 %</i>	Preferred	
<i>ivermectin external lotion 0.5 %</i>	Preferred	
<i>permethrin external cream 5 %</i>	Preferred	
<i>sm lice treatment external liquid 1 %</i>	Preferred	
*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)***		
OSPHENA ORAL TABLET 60 MG (<i>ospemifene</i>)	Preferred	QL (1 EA per 1 day)
*SEMI SOLID VEHICLES***		
<i>baby skin protectant external ointment 41 %</i>	Preferred	
<i>cvs petroleum jelly external gel</i>	Preferred	
<i>daily moisturizer external ointment 41 %</i>	Preferred	
<i>ft petroleum jelly external gel</i>	Preferred	
<i>gnp petroleum jelly external gel</i>	Preferred	
<i>goodsense petroleum jelly external gel</i>	Preferred	
<i>hm petroleum jelly external gel</i>	Preferred	
<i>petrolatum external gel</i>	Preferred	
<i>petrolatum external ointment 42 %</i>	Preferred	
<i>petrolatum white external gel</i>	Preferred	
<i>petroleum jelly external gel , 100 %</i>	Preferred	
<i>qc petroleum jelly external gel 100 %, 99.89 %</i>	Preferred	
<i>sm petroleum jelly external gel</i>	Preferred	
<i>white petrolatum external gel</i>	Preferred	
<i>white petroleum jelly external gel</i>	Preferred	
<i>white petrolatum (Vaseline External Gel)</i>	Preferred	
VASELINE PURE ULTRA WHITE EXTERNAL GEL (<i>white petrolatum</i>)	Preferred	
*SKIN PROTECTANTS***		
ABSORBASE EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
MINERIN CREME EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
*SOAPS***		
ACUWASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AQUA GLYCOLIC FACIAL CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AQUA GLYCOLIC SHAMPOO/BODY EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AQUA GLYCOLIC TONER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
PURPOSE GENTLE CLEANING WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
REHYLA HAIR + BODY CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
REHYLA WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
*SODIUM***		
<i>sodium chloride oral tablet 1 gm</i>	Preferred	
*SOLIDS***		
<i>butylated hydroxytoluene powder</i>	Preferred	
*SOMATOSTATIC AGENTS***		
<i>octreotide acetate injection solution 100 mcg/ml</i>	Preferred	SP; PA
*SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES***		
<i>breathe comfort chamber/adult device</i>	Preferred	
<i>breathe comfort chamber/child device</i>	Preferred	
<i>breathe ease large device</i>	Preferred	
<i>breathe ease medium device</i>	Preferred	
<i>breathe ease small device</i>	Preferred	
<i>eq space chamber anti-static device</i>	Preferred	
<i>eq space chamber anti-static l device</i>	Preferred	
<i>eq space chamber anti-static m device</i>	Preferred	
<i>eq space chamber anti-static s device</i>	Preferred	
<i>pro comfort spacer adult</i>	Preferred	
<i>pro comfort spacer child</i>	Preferred	
<i>pro comfort spacer infant device</i>	Preferred	
<i>procare spacer/adult mask device</i>	Preferred	
<i>procare spacer/child mask device</i>	Preferred	
<i>prochamber vhc device</i>	Preferred	
<i>pure comfort spacer chamber device</i>	Preferred	
AEROCHAMBER HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER MINI CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER MV (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
AEROCHAMBER PLUS FLO-VU MEDIUM (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLOW VU (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER W/FLOWSIGNAL (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS CHAMBR (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS/LARGE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS/MEDIUM (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS/SMALL (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROVENT PLUS DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
BREATHERITE VALVED MDI CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
CLEVER CHOICE HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
COMPACT SPACE CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
COMPACT SPACE CHAMBER/LG MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
COMPACT SPACE CHAMBER/MED MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
COMPACT SPACE CHAMBER/SM MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT MASK LARGE (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT MASK MEDIUM (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT MASK SMALL (<i>spacer/aero-holding chambers</i>)	Preferred	
FLEXICHAMBER ADULT MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	Preferred	
FLEXICHAMBER CHILD MASK/LARGE (<i>spacer/aero-hold chamber mask</i>)	Preferred	
FLEXICHAMBER CHILD MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	Preferred	
FLEXICHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
INSPIREASE (<i>spacer/aero-holding chambers</i>)	Preferred	
MASK VORTEX/CHILD/FROG (<i>spacer/aero-hold chamber mask</i>)	Preferred	
MASK VORTEX/TODDLER/LADYBUG (<i>spacer/aero-hold chamber mask</i>)	Preferred	
MICROCHAMBER (<i>spacer/aero-holding chambers</i>)	Preferred	
MICROCHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
MICROSPACER (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND-LG MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND-MD MASK (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND-SM MASK (<i>spacer/aero-holding chambers</i>)	Preferred	
PANDA MASK LARGE (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PANDA MASK MEDIUM (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PANDA MASK SMALL (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PARI VORTEX ADULT MASK (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PEDIATRIC PANDA MASK (<i>spacer/aero-hold chamber mask</i>)	Preferred	
POCKET CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
POCKET SPACER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
RITEFLO DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
VORTEX HOLD CHMBR/MASK/CHILD DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
VORTEX HOLD CHMBR/MASK/TODDLER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
VORTEX VALVED HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
*SPECIALTY VITAMINS PRODUCTS***		
urosex oral tablet	Preferred	
*SPERMICIDES***		
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (<i>nonoxynol-9</i>)	Preferred	
TODAY SPONGE VAGINAL 1000 MG (<i>nonoxynol-9</i>)	Preferred	
*STIMULANT LAXATIVES***		
bisacodyl ec oral tablet delayed release 5 mg	Preferred	
bisacodyl rectal suppository 10 mg	Preferred	
castor oil oral oil 100 %	Preferred	
chocolated laxative oral tablet chewable 15 mg	Preferred	
ft castor oil oral oil 100 %	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ft gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>ft laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>ft senna laxative oral tablet 8.6 mg</i>	Preferred	
<i>ft senna laxatives oral tablet 8.6 mg</i>	Preferred	
<i>gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>gnp castor oil oral oil 100 %</i>	Preferred	
<i>gnp gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>gnp gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>gnp senna lax oral tablet 8.6 mg</i>	Preferred	
<i>gnp womens gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>laxative max str oral tablet 25 mg</i>	Preferred	
<i>laxative regular strength oral tablet 15 mg</i>	Preferred	
<i>senna oral capsule 8.6 mg</i>	Preferred	
<i>senna oral liquid 8.8 mg/5ml</i>	Preferred	
<i>senna oral syrup 176 mg/5ml, 8.8 mg/5ml</i>	Preferred	
<i>senna oral tablet 8.6 mg</i>	Preferred	
<i>senna-lax oral tablet 8.6 mg</i>	Preferred	
<i>senna-time oral tablet 8.6 mg</i>	Preferred	
<i>sm gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>sm laxative rectal suppository 10 mg</i>	Preferred	
<i>sm senna laxative oral tablet 8.6 mg</i>	Preferred	
<i>womens laxative oral tablet delayed release 5 mg</i>	Preferred	
FLEET BISACODYL RECTAL ENEMA 10 MG/30ML (<i>bisacodyl</i>)	Preferred	
SEKOKOT EXTRA STRENGTH ORAL TABLET 17.2 MG (<i>sennosides</i>)	Preferred	
*SURFACTANT LAXATIVES***		
<i>docusate calcium oral capsule 240 mg</i>	Preferred	
<i>docusate mini rectal enema 283 mg/5ml</i>	Preferred	
<i>docusate sodium oral capsule 100 mg, 250 mg</i>	Preferred	
<i>docusate sodium oral liquid 100 mg/10ml, 50 mg/5ml</i>	Preferred	
<i>ft stool softener oral capsule 100 mg, 250 mg</i>	Preferred	
<i>ft stool softener oral tablet 100 mg</i>	Preferred	
<i>gnp stool softener oral capsule 100 mg, 240 mg, 250 mg</i>	Preferred	
<i>hm stool softener oral capsule 100 mg</i>	Preferred	
<i>sm stool softener oral capsule 100 mg</i>	Preferred	
<i>sm stool softener oral tablet 100 mg</i>	Preferred	
<i>stool softener laxative oral capsule 100 mg</i>	Preferred	
<i>stool softener oral capsule 100 mg</i>	Preferred	

Drug Name	Formulary Status	Requirements/Limits
DOCUSOL KIDS RECTAL ENEMA 100 MG/5ML (<i>docusate sodium</i>)	Preferred	
DOCUSOL MINI RECTAL ENEMA 283 MG/5ML (<i>docusate sodium</i>)	Preferred	
DOK ORAL TABLET 100 MG (<i>docusate sodium</i>)	Preferred	
ENEMEEZ KIDS MINI ENEMA RECTAL ENEMA 100 MG/5ML (<i>docusate sodium</i>)	Preferred	
ENEMEEZ MINI RECTAL ENEMA 283 MG/5ML (<i>docusate sodium</i>)	Preferred	
ENEMEEZ PLUS RECTAL ENEMA 20-283 MG (<i>benzocaine-docusate sodium</i>)	Preferred	
PEDIA-LAX ORAL LIQUID 50 MG/15ML (<i>docusate sodium</i>)	Preferred	
*SYSTEMIC DECONGESTANTS***		
<i>12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>ft nasal decongestant max str oral tablet 30 mg</i>	Preferred	
<i>ft nasal decongestant max str oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>ft nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>gnp nasal decongestant oral tablet 30 mg</i>	Preferred	
<i>gnp nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>gnp pseudoephedrine hcl 12 hr oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>nasal decongestant oral tablet 30 mg</i>	Preferred	
<i>nasal decongestant pe max st oral tablet 10 mg</i>	Preferred	
<i>nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>phenylephrine hcl oral tablet 10 mg</i>	Preferred	
<i>pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>pseudoephedrine hcl oral tablet 30 mg, 60 mg</i>	Preferred	
<i>sinus 12 hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>sinus congestion max strength oral tablet 30 mg</i>	Preferred	
<i>sm nasal decongestant max st oral tablet 30 mg</i>	Preferred	
<i>sm nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>suphedrine 12hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
SUDOGEST MAXIMUM STRENGTH ORAL TABLET 30 MG (<i>pseudoephedrine hcl</i>)	Preferred	
SUDOGEST ORAL TABLET 30 MG, 60 MG (<i>pseudoephedrine hcl</i>)	Preferred	
*TAR PRODUCTS***		
<i>sm anti-dandruff coal tar external shampoo 0.5 %</i>	Preferred	

Drug Name	Formulary Status	Requirements/Limits
<i>therapeutic external shampoo 0.5 %</i>	Preferred	
DHS TAR EXTERNAL SHAMPOO 0.5 % (<i>coal tar extract</i>)	Preferred	
DHS TAR GEL EXTERNAL SHAMPOO 0.5 % (<i>coal tar extract</i>)	Preferred	
IONIL-T EXTERNAL SHAMPOO 1 % (<i>coal tar extract</i>)	Preferred	
*TETRACYCLINES***		
<i>doxycycline hyclate intravenous solution reconstituted 100 mg</i>	Preferred	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	Preferred	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	Preferred	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Preferred	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	Preferred	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	Preferred	
<i>minocycline hcl oral capsule 100 mg, 75 mg</i>	Preferred	QL (2 EA per 1 day)
<i>minocycline hcl oral capsule 50 mg</i>	Preferred	QL (4 EA per 1 day)
<i>doxycycline hyclate (Doxy 100 Intravenous Solution Reconstituted 100 Mg)</i>	Preferred	
*THIAZIDES AND THIAZIDE-LIKE DIURETICS***		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	Preferred	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	Preferred	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	
*THYROID HORMONES***		
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg</i>	Preferred	
<i>niva thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	Preferred	
<i>thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	Preferred	
ADTHYZA ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	Preferred	
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (<i>thyroid</i>)	Preferred	
<i>levothyroxine sodium (Euthyrox Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levothyroxine sodium (Levo-T Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>levothyroxine sodium (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)</i>	Preferred	90-day fill allowed after two 1-month fills

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Drug Name	Formulary Status	Requirements/Limits
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	Preferred	
<i>levothyroxine sodium</i> (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	90-day fill allowed after two 1-month fills
*TOPICAL ANESTHETIC COMBINATIONS***		
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	Preferred	
*TOPICAL DECONGESTANTS***		
<i>12 hour nasal decongestant nasal solution 0.05 %</i>	Preferred	
<i>12 hour nasal spray nasal solution 0.05 %</i>	Preferred	
<i>ft nasal spray nasal solution 0.05 %</i>	Preferred	
<i>gnp nasal four spray nasal solution 1 %</i>	Preferred	
<i>gnp nasal spray extra moist nasal solution 0.05 %</i>	Preferred	
<i>gnp nasal spray fast acting nasal solution 1 %</i>	Preferred	
<i>gnp nasal spray nasal solution 0.05 %</i>	Preferred	
<i>gnp no drip nasal spray nasal solution 0.05 %</i>	Preferred	
<i>nasal decongestant spray nasal solution 0.05 %</i>	Preferred	
<i>nasal four nasal solution 1 %</i>	Preferred	
<i>nasal relief nasal solution 0.05 %</i>	Preferred	
<i>nasal spray 12 hour nasal solution 0.05 %</i>	Preferred	
<i>nasal spray extra moisturizing nasal solution 0.05 %</i>	Preferred	
<i>nasal spray no drip nasal solution 0.05 %</i>	Preferred	
<i>sinus nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sinus relief extra strength nasal solution 1 %</i>	Preferred	
<i>sm nasal spray 12 hour nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray sinus nasal solution 0.05 %</i>	Preferred	
*TRICYCLIC AGENTS***		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>clomipramine hcl oral capsule 25 mg</i>	Preferred	QL (4 EA per 1 day)
<i>clomipramine hcl oral capsule 50 mg</i>	Preferred	QL (5 EA per 1 day)
<i>clomipramine hcl oral capsule 75 mg</i>	Preferred	QL (3 EA per 1 day)
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	Preferred	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Preferred	
<i>imipramine pamoate oral capsule 100 mg, 150 mg, 75 mg</i>	Preferred	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*TRIPHASIC CONTRACEPTIVES - ORAL***		
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estrad triphasic (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estrad triphasic (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorg-eth estrad triphasic (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estrad triphasic (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorg-eth estrad triphasic (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estrad triphasic (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethin-eth estrad triphasic (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindron-ethinyl estrad-fe (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norethindron-ethinyl estrad-fe (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill
<i>levonorg-eth estrad triphasic (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)</i>	Preferred	Max 365-day supply per 1 Fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per 1 Fill
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per 1 Fill
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	Preferred	Max 365-day supply per 1 Fill
*ULCER DRUGS - PROSTAGLANDINS***		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	Preferred	
*URINARY ANALGESICS***		
<i>ft urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>gnp urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>hm urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg, 95 mg</i>	Preferred	
<i>sm urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>sm urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>urinary pain relief oral tablet 95 mg</i>	Preferred	
URO-PAIN ORAL TABLET 95 MG (<i>phenazopyridine hcl</i>)	Preferred	
*URINARY ANTI-INFECTIVES***		
<i>fosfomycin tromethamine oral packet 3 gm</i>	Preferred	
<i>methenamine hippurate oral tablet 1 gm</i>	Preferred	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	Preferred	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	Preferred	
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS***		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	Preferred	
*VASODILATORS***		
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	Preferred	
*VASOPRESSIN***		
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	Preferred	
*VASOPRESSORS***		
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	
*VISCOSUPPLEMENTS***		
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (<i>sodium hyaluronate (viscosup)</i>)	Preferred	PA
*VITAMIN A***		
<i>true vitamin a oral capsule 10000 unit</i>	Preferred	
<i>vitamin a oral capsule 3 mg (10000 ut)</i>	Preferred	
*VITAMIN B-1***		
<i>true vitamin b1 oral tablet 100 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>vitamin b1 oral tablet 100 mg</i>	Preferred	
<i>vitamin b-1 oral tablet 100 mg</i>	Preferred	
*VITAMIN B-2***		
<i>true vitamin b2 oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	
*VITAMIN B-3***		
<i>niacin er oral capsule extended release 250 mg</i>	Preferred	
<i>niacin oral tablet 500 mg</i>	Preferred	
<i>true vitamin b3 oral tablet 100 mg, 250 mg, 50 mg, 500 mg</i>	Preferred	
*VITAMIN B-6***		
<i>sm vitamin b-6 oral tablet 100 mg</i>	Preferred	
<i>true vitamin b6 oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	
<i>vitamin b-6 oral tablet 25 mg</i>	Preferred	
*VITAMIN C***		
<i>ascorbic acid oral tablet 500 mg</i>	Preferred	
<i>sm chewable c oral tablet chewable 500 mg</i>	Preferred	
<i>sm vit c/rose hips oral tablet 1000 mg</i>	Preferred	
<i>sm vitamin c oral tablet 1000 mg, 250 mg</i>	Preferred	
<i>sm vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>sm vitamin c/rose hips oral tablet 500 mg</i>	Preferred	
<i>true vitamin c oral tablet 1000 mg, 250 mg, 500 mg</i>	Preferred	
<i>vitamin c oral tablet 500 mg</i>	Preferred	
*VITAMIN D***		
<i>aqueous vitamin d oral liquid 10 mcg/ml</i>	Preferred	
<i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	Preferred	90-day fill allowed after two 1-month fills
<i>ergocalciferol oral solution 200 mcg/ml</i>	Preferred	
<i>sm vitamin d3 oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>true vitamin d3 oral capsule 1.25 mg (50000 ut), 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut), 250 mcg (10000 ut), 50 mcg, 50 mcg (2000 ut)</i>	Preferred	
<i>true vitamin d3 oral tablet 1.25 mg (50000 ut), 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut)</i>	Preferred	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	Preferred	90-day fill allowed after two 1-month fills
<i>vitamin d oral liquid 10 mcg/ml</i>	Preferred	
<i>vitamin d3 oral capsule 1.25 mg (50000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d3 oral tablet 10 mcg (400 unit)</i>	Preferred	
<i>CALCIDOL ORAL SOLUTION 200 MCG/ML (ergocalciferol)</i>	Preferred	
<i>DECARA ORAL CAPSULE 1.25 MG (50000 UT) (cholecalciferol)</i>	Preferred	
<i>DIALYVITE VITAMIN D 5000 ORAL CAPSULE 125 MCG (5000 UT) (cholecalciferol)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
DIALYVITE VITAMIN D3 MAX ORAL TABLET 1.25 MG (50000 UT) (<i>cholecalciferol</i>)	Preferred	
WEEKLY-D ORAL CAPSULE 1.25 MG (50000 UT) (<i>cholecalciferol</i>)	Preferred	
*VITAMIN E***		
<i>aqueous vitamin e oral solution 15 mg/0.67ml</i>	Preferred	
<i>true vitamin e oral capsule 180 mg, 450 mg, 90 mg</i>	Preferred	
<i>vitamin e oral capsule 180 mg (400 unit), 450 mg (1000 ut)</i>	Preferred	
<i>vitamin e oral solution 15 mg/0.67ml</i>	Preferred	
*VITAMIN K***		
<i>phytonadione oral tablet 5 mg</i>	Preferred	PA
*ZINC***		
<i>sm zinc gluconate oral tablet 50 mg</i>	Preferred	
TOPICAL ANTIBIOTICS [OPEN CLASS]		
<i>mupirocin external ointment 2 %</i>	Preferred	
<i>mupirocin calcium external cream 2 %</i>	Non Preferred	PA
CENTANY AT EXTERNAL KIT 2 % (<i>mupirocin</i>)	Non Preferred	PA
CENTANY EXTERNAL OINTMENT 2 % (<i>mupirocin</i>)	Non Preferred	PA
ULCERATIVE COLITIS [OPEN CLASS]		
<i>balsalazide disodium oral capsule 750 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	Preferred	90-day fill allowed after two 1-month fills
<i>mesalamine er oral capsule extended release 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>mesalamine oral capsule delayed release 400 mg</i>	Preferred	
<i>mesalamine oral tablet delayed release 1.2 gm, 800 mg</i>	Preferred	
<i>mesalamine rectal enema 4 gm</i>	Preferred	
<i>mesalamine rectal suppository 1000 mg</i>	Preferred	
<i>sulfasalazine oral tablet 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>sulfasalazine oral tablet delayed release 500 mg</i>	Preferred	90-day fill allowed after two 1-month fills
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (<i>mesalamine</i>)	Preferred	90-day fill allowed after two 1-month fills
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG, 500 MG (<i>mesalamine</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	Non Preferred	PA
<i>budesonide rectal foam 2 mg, 2 mg/act</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>mesalamine-cleanser rectal kit 4 gm</i>	Non Preferred	PA
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (<i>sulfasalazine</i>)	Non Preferred	PA
AZULFIDINE ORAL TABLET 500 MG (<i>sulfasalazine</i>)	Non Preferred	PA
CANASA RECTAL SUPPOSITORY 1000 MG (<i>mesalamine</i>)	Non Preferred	PA
COLAZAL ORAL CAPSULE 750 MG (<i>balsalazide disodium</i>)	Non Preferred	PA
DELZICOL ORAL CAPSULE DELAYED RELEASE 400 MG (<i>mesalamine</i>)	Non Preferred	PA
DIPENTUM ORAL CAPSULE 250 MG (<i>olsalazine sodium</i>)	Non Preferred	PA
LIALDA ORAL TABLET DELAYED RELEASE 1.2 GM (<i>mesalamine</i>)	Non Preferred	PA
ROWASA RECTAL KIT 4 GM (<i>mesalamine-cleanser</i>)	Non Preferred	PA
SFROWASA RECTAL ENEMA 4 GM/60ML (<i>mesalamine</i>)	Non Preferred	PA
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (<i>budesonide</i>)	Non Preferred	PA
UCERIS RECTAL FOAM 2 MG/ACT (<i>budesonide</i>)	Non Preferred	PA
URINARY ANTISPASMODICS [OPEN CLASS]		
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	Preferred	90-day fill allowed after two 1-month fills
<i>oxybutynin chloride oral tablet 2.5 mg</i>	Preferred	
<i>oxybutynin chloride oral tablet 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	Preferred	90-day fill allowed after two 1-month fills
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	Preferred	
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (<i>fesoterodine fumarate</i>)	Preferred	90-day fill allowed after two 1-month fills
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	Non Preferred	PA
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	Non Preferred	PA
<i>flavoxate hcl oral tablet 100 mg</i>	Non Preferred	PA
<i>mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	Non Preferred	PA
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	Non Preferred	PA
<i>tropium chloride oral tablet 20 mg</i>	Non Preferred	PA
DETROL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 2 MG, 4 MG (<i>tolterodine tartrate</i>)	Non Preferred	PA
DETROL ORAL TABLET 1 MG, 2 MG (<i>tolterodine tartrate</i>)	Non Preferred	PA
GELNIQUE TRANSDERMAL GEL 10 % (<i>oxybutynin chloride</i>)	Non Preferred	PA
GEMTESA ORAL TABLET 75 MG (<i>vibegron</i>)	Non Preferred	PA
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML (<i>mirabegron</i>)	Non Preferred	PA
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (<i>mirabegron</i>)	Non Preferred	PA
OXYTROL FOR WOMEN TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (<i>oxybutynin</i>)	Non Preferred	PA
OXYTROL TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (<i>oxybutynin</i>)	Non Preferred	PA
VESICARE LS ORAL SUSPENSION 5 MG/5ML (<i>solifenacin succinate</i>)	Non Preferred	PA
VESICARE ORAL TABLET 10 MG, 5 MG (<i>solifenacin succinate</i>)	Non Preferred	PA
VACCINES		
*BACTERIAL VACCINES***		
BIOTHRAX INTRAMUSCULAR SUSPENSION (<i>anthrax vaccine adsorbed</i>)	Preferred	QL (2.50 ML per Lifetime); AGE (Min 19 Years)
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 21-valent conjuga</i>)	Preferred	AGE (Min 18 Years)
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 20-val conj vacc</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML (<i>typhoid vi polysaccharide vacc</i>)	Preferred	QL (0.50 ML per Lifetime); AGE (Min 19 Years)
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (<i>typhoid vi polysaccharide vacc</i>)	Preferred	QL (0.50 ML per Lifetime); AGE (Min 19 Years)
VAXCHORA ORAL SUSPENSION RECONSTITUTED (<i>cholera vac live attenuated</i>)	Preferred	QL (100.00 ML per Lifetime); AGE (Min 19 Years)
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 15-val conj vacc</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
VIVOTIF ORAL CAPSULE DELAYED RELEASE (<i>typhoid vaccine</i>)	Preferred	QL (4.00 ML per Lifetime); AGE (Min 19 Years)

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Drug Name	Formulary Status	Requirements/Limits
*TOXOID COMBINATIONS***		
<i>tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml</i>	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	Preferred	PA; AGE (Min 19 Years)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML (<i>tetanus-diphtheria toxoids td</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU (<i>tetanus-diphtheria toxoids td</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recomb</i>)	Preferred	PA; AGE (Min 19 Years)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recomb</i>)	Preferred	PA; AGE (Min 19 Years)
*VIRAL VACCINE COMBINATIONS***		
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (<i>hepatitis a-hep b recomb vac</i>)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
*VIRAL VACCINES***		
<i>stamaril injection suspension reconstituted</i>	Preferred	QL (1.00 ML per Lifetime); AGE (Min 19 Years)
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (<i>rsv pre-fusion f a&b vac rcmb</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
ACAM2000 INJECTION SOLUTION RECONSTITUTED (<i>smallpox vaccine</i>)	Preferred	
AFLURIA INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (<i>rsvpref3 vac recomb adjuvanted</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 60 Years)
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac a&b surf ant adj</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (<i>influenza vac recombinant ha</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION (<i>influenza vac tiss-cult subunt</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac tiss-cult subunt</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)

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FLUMIST NASAL LIQUID (<i>influenza virus vaccine live</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 18 Years)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac split high-dose</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (<i>hepatitis b vac recomb adj</i>)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML (<i>rabies virus vaccine, hdc</i>)	Preferred	
IPOL INJECTION INJECTABLE (<i>poliovirus vaccine inactivated</i>)	Preferred	QL (1.50 ML per Lifetime); AGE (Min 19 Years)
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chikungunya virus vaccine live</i>)	Preferred	QL (0.50 ML per Lifetime); AGE (Min 19 Years)
IXIARO INTRAMUSCULAR SUSPENSION (<i>japanese encephalitis vac inac</i>)	Preferred	QL (1.00 ML per Lifetime); AGE (Min 19 Years)
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML (<i>smallpox & monkeypox vac, live</i>)	Preferred	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>rsv mrna pre-f virus vaccine</i>)	Preferred	QL (1 Fill per Lifetime); AGE (Min 60 Years)
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (<i>zoster vac recomb adjuvanted</i>)	Preferred	QL (2 Fills per Lifetime); AGE (Min 18 Years)
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML, 2.4 MCG/0.5ML (<i>tick-borne encephalitis vacc</i>)	Preferred	QL (1.50 ML per Lifetime); AGE (Min 19 Years)
YF-VAX SUBCUTANEOUS INJECTABLE (<i>yellow fever vaccine</i>)	Preferred	QL (1.00 ML per Lifetime); AGE (Min 19 Years)
VAGINAL ANTIBIOTICS [OPEN CLASS]		
<i>metronidazole vaginal gel 0.75 %</i>	Preferred	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	Preferred	
CLINDESSE VAGINAL CREAM 2 % (<i>clindamycin phosphate (1 dose)</i>)	Preferred	
NUVESSA VAGINAL GEL 1.3 % (<i>metronidazole</i>)	Preferred	
<i>clindamycin phosphate vaginal cream 2 %</i>	Non Preferred	PA
CLEOCIN VAGINAL CREAM 2 % (<i>clindamycin phosphate</i>)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
VANDAZOLE VAGINAL GEL 0.75 % (<i>metronidazole</i>)	Non Preferred	PA
XACIATO VAGINAL GEL 2 % (<i>clindamycin phosphate</i>)	Non Preferred	PA
VAGINAL ESTROGENS [OPEN CLASS]		
<i>estradiol vaginal cream 0.1 mg/gm</i>	Preferred	
<i>estradiol vaginal tablet 10 mcg</i>	Preferred	AGE (Min 18 Years)
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	Preferred	
VAGIFEM VAGINAL TABLET 10 MCG (<i>estradiol</i>)	Preferred	AGE (Min 18 Years)
<i>estradiol</i> (YuvaFem Vaginal Tablet 10 Mcg)	Preferred	AGE (Min 18 Years)
ESTRACE VAGINAL CREAM 0.1 MG/GM (<i>estradiol</i>)	Non Preferred	PA
ESTRING VAGINAL RING 2 MG, 7.5 MCG/24HR (<i>estradiol</i>)	Non Preferred	PA
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (<i>estradiol acetate</i>)	Non Preferred	PA
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (<i>estradiol</i>)	Non Preferred	PA
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (<i>estradiol</i>)	Non Preferred	PA
WEIGHT MANAGEMENT AGENTS [CLOSED CLASS]		
<i>benzphetamine hcl oral tablet 50 mg</i>	Preferred	PA; AGE (Min 16 Years)
<i>diethylpropion hcl er oral tablet extended release 24 hour 75 mg</i>	Preferred	PA; AGE (Min 16 Years)
<i>diethylpropion hcl oral tablet 25 mg</i>	Preferred	PA; AGE (Min 16 Years)
<i>orlistat oral capsule 120 mg</i>	Preferred	PA; AGE (Min 12 Years)
<i>phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg</i>	Preferred	PA; AGE (Min 16 Years)
<i>phendimetrazine tartrate oral tablet 35 mg</i>	Preferred	PA; AGE (Min 16 Years)
<i>phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg</i>	Preferred	PA; AGE (Min 16 Years)
<i>phentermine hcl oral tablet 37.5 mg</i>	Preferred	PA; AGE (Min 16 Years)
XENICAL ORAL CAPSULE 120 MG (<i>orlistat</i>)	Preferred	PA; AGE (Min 12 Years)
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (<i>setmelanotide acetate</i>)	Non Preferred	SP; PA; AGE (Min 6 Years)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide -weight management</i>)	Non Preferred	PA; AGE (Min 12 Years)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML (<i>semaglutide-weight management</i>)	Non Preferred	PA; AGE (Min 12 Years)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (<i>tirzepatide-weight management</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)

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